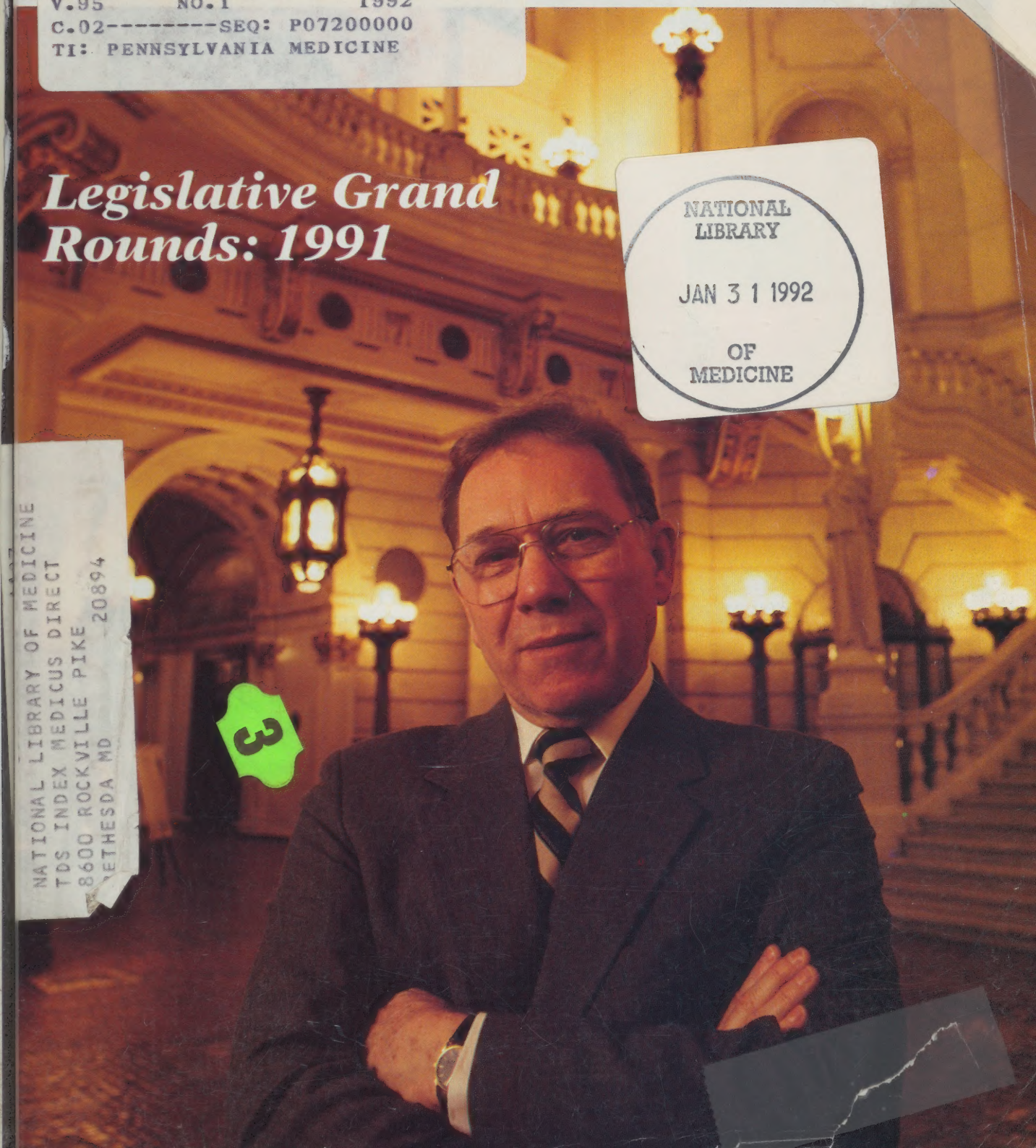
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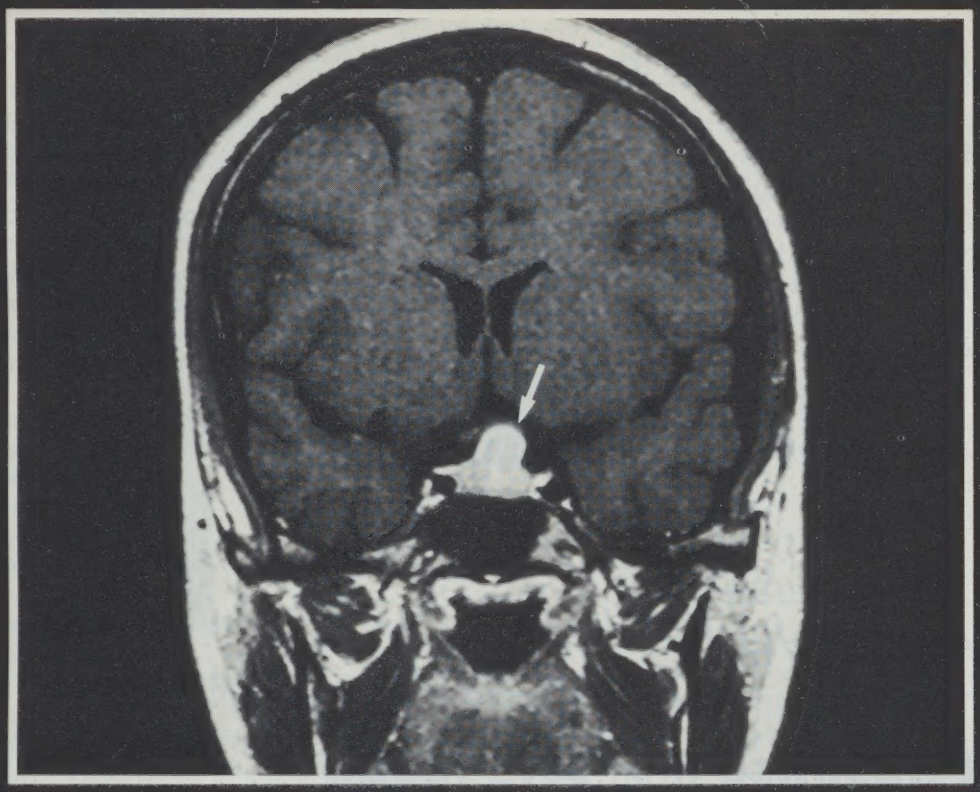
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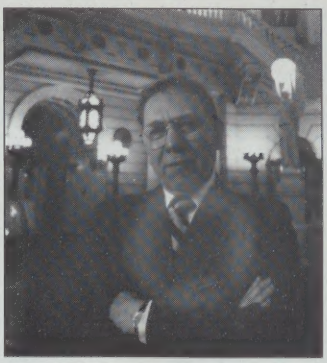
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PENNSYLVANIA MEDICINE (ISSN 0031-4595) is published monthly by the Pennsylvania Medical Society, 777 East Park Drive, Harrisburg, PA 17111.
SUBSCRIPTIONS: $20 per year— United States and Canada; $30—all others. Single issues $3.00 per copy prepaid; special issues cost more.
POSTMASTER: Send address changes to PENNSYLVANIA MEDICINE, 777 East Park Drive, PO Box 8820, Harrisburg, PA 17105–8820. Second class postage paid at Harrisburg, PA 17105.



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SOCIETY OPPOSES 113 PERCENT OF MEDICARE WORKERS' COMPENSATION CAP: Though supportive of cost containment reform for the state's workers' compensation system, **the Society opposes measures within House Bill 2140, passed 121-80 in December. That bill would cap providers' fees at 113 percent of the Medicare allowance. The Society opposes any linkage of workers' compensation to Medicare. It has developed a payment system which also reforms the submission, processing, and adjudication of claims for workers' comp health care services.** The Society plan would provide a more realistic reduction in costs for employers and lessen administrative hassles and disputed claims over medical services. Senate action on the issue is likely soon after the legislature reconvenes in late January. PHYSICIANS ARE URGED TO CONTACT THEIR SENATORS IMMEDIATELY TO OPPOSE MEDICARE LINKAGE AND SUPPORT THE SOCIETY'S PROPOSALS FOR REFORM.

BLUE SHIELD BEGINS MONITORING MEDICARE PROVISION OF OBRA '89: Pennsylvania Blue Shield (PBS), as the state's Medicare carrier, is monitoring Medicare beneficiary claim submission deadlines as of January 1, 1992. OBRA '89 requires all physicians to submit claims for Medicare beneficiaries beginning with service dates on or after September 1, 1990. The policy includes a *10 percent reduction* in payment of the Medicare share in the allowance for assigned claims which are not received by PBS within *one year* of date of service. Providers will now begin to see the 10 percent reduction applied if the one-year rule is not met. Note: the beneficiary's liability is *not* affected by the 10 percent reduction, and physicians cannot recoup the reduction from the beneficiary. For additional information, contact the State Society's Council on Medical Economics.

SOCIETY OFFERING RBRVS-RELATED SEMINARS AND PUBLICATIONS: In addition to this month's RBRVS regional meetings for physicians, the Society is offering a special workshop and a series of publications to help members use the new Medicare payment system. The workshop, for physicians *and their office staff* on "How to Master the *New* CPT Codes," will be held:

January 28, Greentree Marriott, Pittsburgh
January 29, State Society Headquarters, Harrisburg
January 30, Holiday Inn, King of Prussia
February 4, Hilton, Allentown
February 5, Bel Aire Hotel, Erie
February 6, Holiday Inn—Penn State, State College

Workshops are from 9:00 a.m.-4:00 p.m. Tuition is $195 for members and their office staff and $225 for non-members; enrollment is limited to 75 attendees at each location. For registration information, call the Society's Department of Meeting Services at 1-800-228-7823.

Publications available about related issues include: *Visit Code Information Kit* (includes analysis of E/M coding system)—complimentary to members, not available to non-members; *Medicare Evaluation and Management Codes: A Pocket Reference for Physicians*—first copy complimentary to members/additional copies $2.00 each, $5.00 per copy for non-members; *Medicare Physician Payment: Before and After RBRVS* (currently under development)—first copy complimentary to members/additional copies $2.00 each, $5.00 per copy for non-members; and *Practice Management Consulting Network*—first copy complimentary to members/additional copies $2.00 each, $5.00 per copy for non-members. To order, send name, address, phone number, and check to the State Society's Department of Physician Services in Harrisburg (Pennsylvania residents add 6 percent sales tax).

HCFA 1500 CLAIM FORM DEADLINE: Physicians are reminded that mandatory use of the revised HCFA 1500 claim forms, submitted on behalf of Medicare patients, will become effective on May 1, 1992. Until then, Medicare will accept the current version of the HCFA 1500 form.

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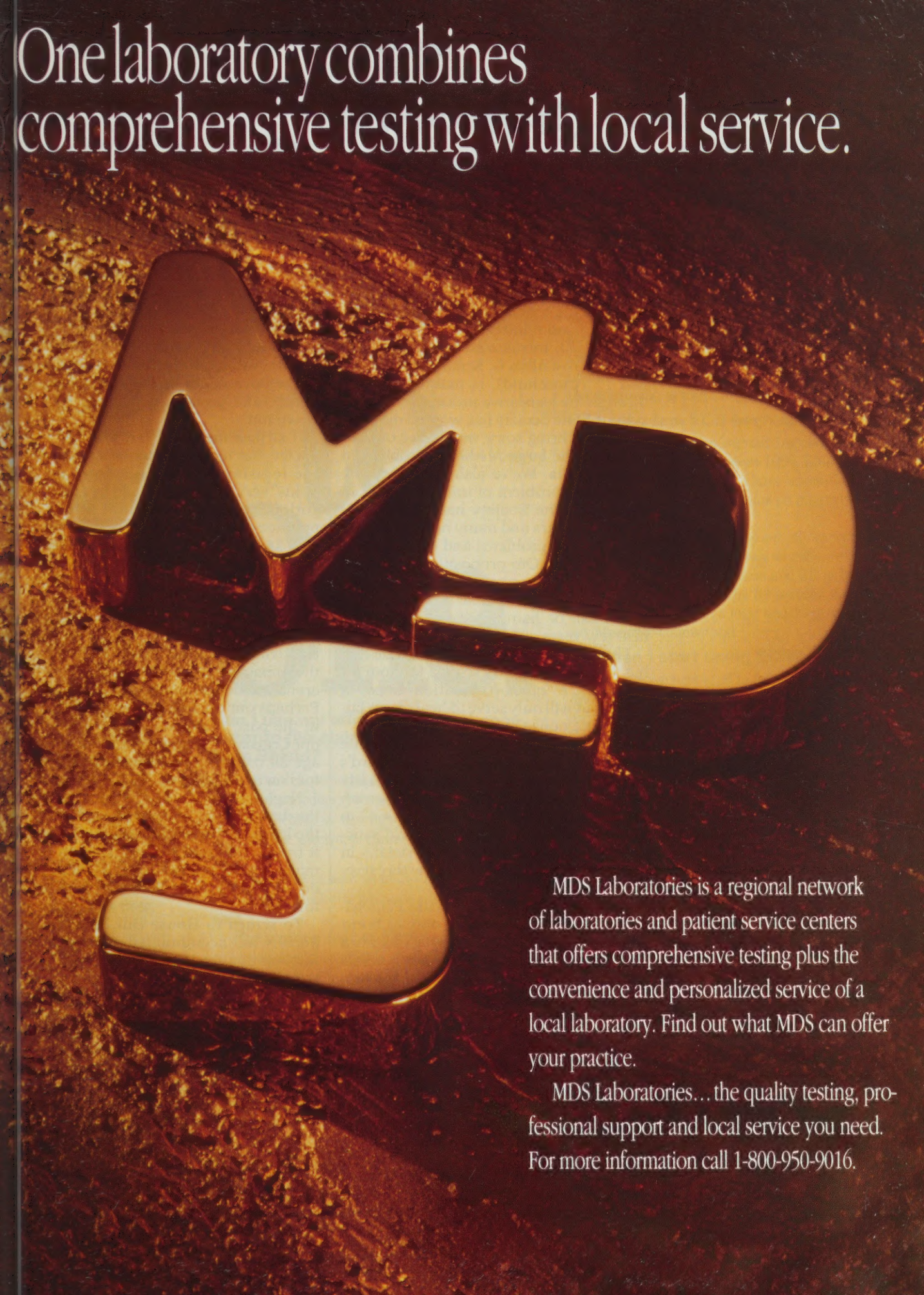
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No Quick-Fix Solutions For Medicine

John W. Mills, MD
Medical Editor

Pennsylvania is on its way to having a new law regulating Medicaid reimbursement. House Bill 20, introduced by Representative Allen G. Kukovich (D-Westmoreland), is making its way through the legislative process.

Your State Society has worked diligently to try to bring some semblence of a solution to the large Medicaid problem in Pennsylvania. We've also addressed the even larger problem of uninsured folk in this state. The Society has spent thousands of dollars and many hours trying to delineate the problems and offer reasonable solutions. Our propositions are wide-ranging, as they attempt to address the myriad of aspects so that a workable solution can be hammered out during the next few years.

This is not a new problem; it is one that has been steadily worsening for four or five years. A "quick-fix solution" is not in order, but will only serve to heap more bureaucratic nonsense on the people.

The Democratic House seems to be buoyed up by Senator Harris Wofford's sweep in November. At this writing (early December 1991), Representative Kukovich has reasserted his "quick-fix solution" in House Bill 20. While efforts to add sanctions for non-participating physicians in Medicaid failed in the House, the threat remains.

Quick fixes are typical of the Pennsylvania legislature and serve only to boost the sponsors of the legislation to even higher political levels, while bureaucrats are left to do the implementation and enforcement. We have seen it with the "MOM" bill and with auto insurance. We may even see it with workers' compensation. Doesn't it strike you that something is wrong "on the hill?"

When we needed a quick-fix solution on the living will, we couldn't get one. December 1, 1990, was the implementation date of the Patient Self Determination Act (a federal law) throughout the country, and we at the State Society have been pushing for a living will law since 1983. Still, when the legislature adjourned for the 1991 holiday recess, no living will bill had yet been passed.

The fact is, the Pennsylvania legislature has its own agenda, which often serves mainly as a springboard for higher political aspirations. Unfortunately, that's one of the advantages or disadvantages of a Democratic process, depending on your viewpoint.

It strikes me, however, that the State Society has not been very well received by the legislature. While I don't expect "wins" very often, we should be able to negotiate on any subject that affects the practice of medicine. Part of the problem may be ours. We, as physicians, sometimes fail to understand the political process, and we rarely contact our legislators to express our concerns.

The most important focus of the Society's lobbying expertise should be within the field of medical practice, to temper the impact of proposed legislation in that arena, as well as on the "patient" public. Perhaps our credibility has been dimmed in the past. If so, we need to strengthen our Legislative Action Teams and encourage all members to contact their legislators on a *regular basis*.

Negotiation seems to be the by-word of the day. The idea of "winning or losing" in the legislative arena is passé. Let's look at it from a different perspective and try to make legislators realize that what they do—*and don't do*—affects every person in this state.

To return to House Bill 20, the State Society has accumulated more accurate information on the Medicaid and uninsured problem in this state than anyone else. Hopefully, we can get someone to listen to our well-founded statistics and well-thought-out proposals. Implementation would require legislation as well as other activity, but there is no reason why our proposal would not work in Pennsylvania and be a model for the rest of the country—as Oregon's Medicaid experiment is also an attempt to deal with the uninsured/underinsured/Medicaid morass.

We have the expertise, and we have the information. All we need is open-minded listening by the legislative leadership.

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If you have a question, please write Dr. Ricci at: Pennsylvania Blue Shield, P.O. Box 890089, Camp Hill, PA 17089.

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Who Will Mold Health Care Reform?

Robert N. Moyers, MD

Washington, DC, is abuzz with up to 30 plans to revise the health care system of the United States, according to Senate Minority Leader Robert Dole (R-KS).

Senator Dole was one of the speakers at a recent Health Care Forum hosted by Congressman Curt Weldon (R-PA 7th), attended by about 150 representatives of health care provider organizations from Delaware County and surrounding areas. I also had the opportunity to attend, along with other Society leaders, members of the Council on Governmental Relations, and staff.

It is important for you to hear some of what was said. Regardless of our individual political persuasions, physicians must recognize that health care is on front stage, courtesy of Pennsylvania's newest senator, Harris Wofford. To ignore this growing debate, hoping that it may somehow resolve itself or go away, is no longer possible. If there is any doubt, ask Dick Thornburgh.

Here are some of the opinions expressed at the forum in November:

• Senator Dole predicted there will be radical changes in health care within the next five years, as the country attempts to reconcile the $365 billion spent on health care with the fact that 37 million Americans remain uninsured or underinsured.

• Gail Wilensky, administrator of the Health Care Financing Administration, said that she and others in government believe that some form of managed care results in the most effective cost control, whereas fee-for-service rewards a practitioner for doing more and is therefore undesirable. She said there are no easy answers, no right answers, and that any final system will involve tradeoffs and compromises. Her first priority, however, is restraining increasing costs. She closed her brief presentation by asking, "What are you—the public and providers—willing to do to control costs?"



• Senator Arlen Specter (R-PA) admitted that "it's an open secret that we do not have all the answers," and urged input by all segments of society, especially the provider community.

• Representative Jim McDermott, MD (D-WA), a psychiatrist and member of the House Ways and Means Committee, believes that access to care is a right, but that rationing is not to be feared. He favors a single-payer system for simplicity of administration and as the only way to control costs by imposing caps on appropriations.

• Representative Nancy Johnson (R-CT) stressed the difference between the U.S and Canadian health care systems. She said she did not believe that the U.S. patient would tolerate the decreased access to high-tech services that would eventually result from a Canadian-type system.

The speakers' plans can be summarized as: 1) employer-based play or pay; 2) single-payer; 3) patch up the present system; and 4) throw out everthing and start from scratch. There is general agreement that no plan is perfect, and there will be variations on any one of them.

Our future system of medical care is presently being drafted in the forum of public opinion. In our political process, those in government will write into law what they perceive their constituents want. Physicians are the vital profession in the health care system, and therefore have the unique opportunity and responsibility to aggressively take the initiative to educate legislators and build patient-voter coalitions. Now, as never before, every physician must become informed on the various plans that are coming before Congress. The State Society and the American Medical Association work to evaluate and keep members up-to-date on the many bills that come before Congress.

It is time we begin to deal with these issues from a position of strength—and strength comes from unity of effort and widespread participation. I urge doctors to take five minutes a week to talk to their legislators, in order to establish cordial, regular communication. I also encourage county medical societies to invite local legislators to their meetings.

Our legislators and congressional representatives cannot serve our needs or address our concerns if they do not know what they are. The responsibility is ours. Are we willing to meet it?

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University of California
Division of Cardiology
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San Francisco, CA

January 15, 1992

INFLAMMATORY BOWEL DISEASE
Harris R. Clearfield, MD
Professor of Medicine
Director, Division of Gastroenterology
Hahnemann University

January 22, 1992

CONVERSIONS FROM CHRONIC TO ACUTE CORONARY SYNDROMES
James T. Willerson, MD
Professor and Chairman
Department of Internal Medicine
University of Texas Medical School
Houston, TX

CONVENTIONAL ANTITHROMBOTIC THERAPY (ASPIRIN & WARFARIN) IN PRIMARY & SECONDARY PREVENTION OF CORONARY ARTERY DISEASE
James H. Chesebro, MD
Professor of Medicine
Mayo Medical School
Consultant in Cardiovascular Diseases
Mayo Clinic
Rochester, MN

January 29, 1992

MOHS SURGERY IN THE TREATMENT OF SKIN CANCER
Nathan R, Howe, MD, PhD
Assistant Professor of Medicine (Dermatology)
Chief, Section of Dermatologic Surgery
Division of Dermatology
Hahnemann University

February 1992

February 5, 1992

PREVENTION OF RENAL FAILURE IN THE GERIATRIC PATIENT
Michael F. Michalis, MD
Professor of Clinical Medicine
New York Medical College
Director, Division of Nephrology
Lenox Hill Hospital

February 12, 1992

GENITAL HERPES
Lawrence Corey, MD
Professor of Laboratory Medicine, Microbiology and Medicine
Head, Virology Division
University of Washington
Seattle, WA

February 19, 1992

CUTANEOUS MANIFESTATIONS OF SYSTEMIC DISEASE
Cherie M. Ditre, MD
Assistant Professor of Medicine
Division of Dermatology
Hahnemann University

February 26, 1992

CARDIOVASCULAR DISORDERS AND ATHEROSCLEROSIS IN POST-MENOPAUSAL WOMEN
Jay Michael Sullivan, MD
Professor of Medicine
Chief, Division of Cardiovascular Diseases
University of Tennessee College of Medicine
Memphis, TN

March 1992

March 4, 1992

CLINICAL PATHOLOGICAL CONFERENCE
VIOLACEOUS MACULAR RASH, HEPATOMEGALY, FEVER AND NEUROLOGIC ABNORMALITIES
Edward Dimitry, MD
Chief Resident, Department of Medicine
Hahnemann University
Cathy Jensen, MD
Chief Resident, Department of Medicine
Hahnemann University
Richard Maniglia, MD
Chief Resident, Department of Medicine
Hahnemann University
Jay Patel, MD
Chief Resident, Department of Medicine
Hahnemann University

March 11, 1992

CARDIOLOGY - ISSUES AND ANSWERS FOR THE 90's
Sylvan L. Weinberg, MD
Clinical Professor of Medicine
Wright State University
Dayton, OH

March 18, 1992

OCULAR MANIFESTATIONS OF AUTOIMMUNE DISEASE
Stephen Sinclair, MD
Professor of Ophthalmology
Vice Chairman, Department of Ophthalmology
Hahnemann University

March 25, 1992

HYPERTENSIVE NEPHROSCLEROSIS: IS IT BENIGN?
Jerome Porush, MD
Professor of Medicine
SUNY Health Science Center
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PINNOCHIO TRAVELS TO OZ

Editor's Note: The following letter was originally published in the October 1991 issue of the Berks County Medical Record. *It was written at the suggestion of William Alexander, MD, of Reading, who was accompanied to the AMA House of Delegates meeting by the author. The article was subsequently submitted to* PENNSYLVANIA MEDICINE *for publication consideration by the State Society's Department of Membership.*

Perhaps some would consider it sacrilegious to refer to the AMA in terms of a fairy tale. Yet, there are physicians who think of the AMA as a monolithic, self-serving leviathan in the Land of Oz (Chicago) that does not concern itself with the needs of the individual physician in private practice, but rather is only concerned with perpetuating its own existence on its own terms. In other words, these physicians believe that the AMA does not exist in the real world, but rather exists in "never, never land." Well, allow me (Pinnochio) to tell you about my recent trip to the Land of Oz to attend the AMA's Annual House of Delegates meeting.

As I begin this journey, I must tell you that I was a non-believer regarding the AMA. When our Pennsylvania House of Delegates approved unifying with the AMA two years ago, I was greatly concerned about the membership losses our county society would suffer. I knew that 75 percent of our membership were AMA members prior to unification, but was concerned that physicians might be losing their "freedom of choice" in the matter. Physicians are trained to be independent thinkers, and unification was no longer allowing the AMA membership choice! I believed that this whole concept of forced membership could spell disaster for the continual membership growth we had experienced in our county. But in Oz, Pinnochio saw otherwise.

This year's AMA House of Delegates was held at the Chicago Hilton and Towers, located on North Michigan Avenue in downtown Chicago. The Pennsylvania Delegation consisted of 24 delegates and 24 alternate delegates. The Pennsylvania delegation met to caucus prior to the official opening of the AMA House of Delegates and then at 7:00 a.m. each day of the convention. It was at these caucus meetings that the resolutions of each of the reference committees were reviewed by the delegation.

The resolutions had been submitted by state medical societies from across the nation. An individual physician could submit a resolution for consideration, but it had a much greater chance of passing if it was endorsed by the state society from which it originated. Reference committees reviewed 263 resolutions and recommended to the full session of the House whether a resolution should or should not be supported.

Two of the biggest issues considered at the meeting were HIV testing for physicians and the federal government's Medicare reimbursement system (RBRVS). These issues were as "hot" as had been anticipated prior to the meeting, and created much discussion and debate on the floor of the House. This "floor activity" was the most exciting part of my trip. All voices were heard and all views represented. I was comforted to hear the concerns of our county physicians addressed by these national leaders who have the power to influence and/or change the practice of medicine as we know it today.

An additional highlight of my trip was hearing Vice President Dan Quayle address the AMA House of Delegates. Security in the auditorium prior to the Vice President's speech was extremely tight, so I was absolutely stunned when a middle-aged woman with press credentials ran towards him from the back of the auditorium screaming, "People with AIDS need national health care, people with AIDS need national health care," as the Vice President had barely spoken five words of his opening speech! This woman was quickly removed from the auditorium, and the Vice President didn't miss a beat by stating to the audience's delight, "This is going to be more fun than I anticipated!" I must say I was quite impressed with Vice President Quayle!

In summing up my journey to Chicago, I would call it exhilarating, enlightening, and energizing. I believe our physicians can take comfort in the very fine leadership we have in our Pennsylvania Delegation. I can also assure our physicians that their concerns are being addressed and that the AMA *does* care about the problems facing physicians in private practice throughout our 67 counties. The system works! I am a witness, and I only hope the Berks County Medical Society Executive Council allows Pinnochio (that's me) to return to the Land of Oz (that's Chicago) to see the AMA House of Delegates in action at some future point in time. I know it will be well worth the wait.

Bruce R. Weidman
Executive Director
Berks County Medical Society

COST CONTAINMENT CLARIFICATION

In the September 1991 issue of PENNSYLVANIA MEDICINE, in the article entitled, "The Cost of Monitoring Medical Care in Pennsylvania," there is a reference to the cost of the Pennsylvania Health Care Cost Containment Council's operation for the year 1989. For the sake of any future reference to these figures, I would like to clarify that the total operating cost for PHC4 for fiscal year ending June 30, 1989, was $2.5 million, not $4.6 million as stated.

Thank you very much for your attention to this matter.

Ernest J. Sessa
Executive Director
Pennsylvania Health Care Cost Containment Council

Editor's Note: In order to clarify the source of the information, the preceeding letter was forwarded to the lead author of the article. His response follows.

I appreciate Mr. Sessa's careful reading of our paper. Our figure for the 1989 PHC4 budget of $4.6 million was properly referenced to a July 3, 1989, front-page story in the *Philadelphia Inquirer*. Apparently, Mr. Sessa, as executive director of the Health Care Cost Containment Council, has more accurate information, and we appreciate his willingness to clarify the data.

David J. Shulkin, MD
University of Pennsylvania School of Medicine

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Wednesday, February 5, 1992

Angina Pectoris: Diagnosis and Management

Moderator: William J. Untereker, MD

3:00-3:30	Outpatient cardiac catheterization: Is it safe, feasible, and for whom?	*William J. Untereker, MD*
3:30-4:00	Recognition and management of patients with angina pectoris: Who needs catheterization?	*J. David Ogilby, MD*
4:00-5:00	Case Presentations	*Scott Fuchs, MD*
	Panel Discussion	*William Corin, MD* *Ancil A. Jones, MD* *Robert I. Katz, MD*

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Legislative Grand Rounds: 1991

Division of Governmental Affairs

As a result of governmental intervention, physicians in Pennsylvania and across the country are no longer just practicing medicine. Legislative battles and burdensome regulatory land mines have become as routine as daily hospital rounds.

As we embarked on the new legislative session last January, your State Society leaders were acutely aware of the difficult medical issues that would be considered and debated by our Congress and state General Assembly. It is no secret, however, that medicine and government have become entwined in a political stranglehold that threatens the very survival of every physician's practice. While concern over sky-rocketing costs of health care continues to gain momentum, the recent campaign platform of Pennsylvania's U.S. Senator Harris Wofford is testament that the issue of health care will be in the forefront of many politicians' agendas in this election year.

In an effort to combat government's encroachment into the practice of medicine, the Pennsylvania Medical Society's Division of Governmental Affairs is dedicated to the task of helping shape medical policy for all Pennsylvanians. To meet this burgeoning challenge, the Division's registered lobbyists work continuously to monitor the multitude of legislative proposals that are put forth under the Capitol dome.

In retrospect, the past legislative year has been anything but mundane. The General Assembly addressed a number of critical issues facing the medical community. However, thrown into that mix were other important issues that significantly bogged down the political process. Soon after the new session began, discussions about the state's financial condition and how best to solve the crisis took center stage. After months of heated debate, the issue was finally laid to rest nearly five weeks after the June 30 deadline.

With the budget crisis temporarily behind them, lawmakers began working behind the scenes on the re-apportionment of Pennsylvania's congressional districts and the re-drawing of the state's Senate and House districts. This exercise, which occurs once every 10 years, predictably sends this body into an emotional tailspin, with members fighting to protect their own turf. Moreover, the legislature recently spent weeks strategizing and hours debating the emotionally charged issue of school choice for Pennsylvania's children.

Within the fold of this busy and controversial agenda, lawmakers addressed such medical issues as indigent care, workers' compensation, and living will legislation. Although these three measures remain in the political and medical "spotlight," other matters—such as expanding the practice of optometry to include therapeutic drugs, removing qualifications for the state's Secretary of Health, and imposing penalties for drug-related offenses for physicians—were successfully stopped or amended.

Indigent care

Throughout 1991 medicine came under fire from lawmakers at both the state and federal levels. Topping the political agenda at the state level has been the issue of health care for the medically indigent. In an effort to solve this problem, Representative Allen G. Kukovich (D-Westmoreland) introduced House Bill 20, a comprehensive proposal aimed at ensuring access to care for children, Medical Assistance (MA) recipients, and the uninsured. However, the tremendous cost of such a proposal was quickly recognized as a significant problem.

In its original form, House Bill 20 included several provisions which the Society found to be onerous. Many of the proposed sanctions and mandates for physicians were gradually removed as the bill moved through a maze of House committees. One provision aimed at assuring MA participation by reducing payments to hospitals which have non-Medicaid participating physicians on their staff, was finally deleted from the package at the last minute.

The Society, through two physician committees, initiated and reviewed several proposals to address aspects of the bill which had not yet been resolved. These included ensuring equal access for MA recipients and maximizing physician participation. While proponents of the bill and the Society had agreed, in concept, that referral networks in certain areas of

The staff members of the Society's Division of Governmental Affairs are: Jerry L. Rothenberger, vice president; Larry L. Light, director, and David J. Thompson, assistant director of legislative affairs; Donald N. McCoy, director, and Frani Battista, assistant director of regulatory affairs and specialty legislation.

the state and for specified medical specialties were appropriate, agreement on the proper means to maximize physician participation in providing care to MA recipients was not reached. As a result, this concept was *not* included in the final version of the House-passed bill.

Workers' compensation

Citing escalating costs in all areas of the state's workers' compensation program, efforts have begun to reform the "comp" system. Stimulus for reform came as the result of the business taxes imposed by the state and the proposed 52 percent increase for workers' comp insurance.

Health costs, representing 35-40 percent of the total costs of workers' comp, have been targeted for change. The governor has proposed capping payment for medical costs by using a percentage of the Medicare allowance as a benchmark. This rationale is similar to that which was used in seeking changes to the auto insurance law. The Society is proposing a series of changes to the system to establish reasonable payments for health care and to streamline the processing adjudication of claims. Significant action is expected in early 1992.

Living wills

The battle continues in the ongoing debate about enacting living will legislation. Unlike last session, both Houses have passed comparable, but not identical, pieces of legislation to address this issue. Until recently, action on one of these bills was expected before the holiday recess due to the federal requirements mandating disclosure of a living will policy by health care facilities. Both bills, Senate Bill 3 and House Bill 2017, feature optional living will formats including "pregnancy" language that would void the document for pregnant women in certain circumstances.

Medicare fee reform

Federal attention for the past six months has focused on the regulations outlining the Health Care Financing Administration's (HCFA's) implementation plan for Medicare Physician Payment Reform. The release of the Notice of Proposed Rulemaking in the June 5, 1991, *Federal Register* described the resource based relative value scale (RBRVS), which contained a 16 percent reduction from the originally proposed conversion factor. This reduction sparked the largest and most successful grassroots legislative effort ever undertaken by organized medicine.

Before it was over, 384 of the 535 members of Congress, including the entire Pennsylvania congressional delegation,

"In retrospect, the past legislative year has been anything but mundane."

The PaMPAC difference

PaMPAC, the Pennsylvania Medical Political Action Committee, is a prominent political force and recognized as one of the state's largest political action committees. During the last legislative session, PaMPAC contributed more than $350,000 to candidates seeking elected state offices.

Although it is important to remember that political contributions do not "buy" votes, financial support for persons believed to be "friends" of medicine strengthens communication on issues of interest to organized medicine. Presently, physicians who recognize the importance of PaMPAC's activities are asked to contribute $100 to become a sustaining member or $250 to become a member of the PAC's Keystone Club. PAC participation does make a difference by sending a clear and unified message to legislators that physicians are attuned to the political process and not simply existing in the vacuum of the medical world.

Given the present political climate, the issue of reapportionate, and the perception of the general public about the high cost of medical care, election year 1992 will most assuredly create an exciting display of political grandstanding on health care issues and a great demand on PAC resources. If the physician community chooses not to become more personally involved in these arenas, lawmakers will continue their efforts to control health care costs by smothering the profession with burdensome legislation and regulations. To meet such challenges of organized medicine, PaMPAC is embarking on a new membership campaign not only to increase levels of contributions but also to further educate physicians about the political process.

"As a group interested in the health and welfare of all Pennsylvanians, organized medicine is well poised to be part of the political agenda. . ."

had joined thousands of physicians in petitioning HCFA to restore the conversion factor to the original budget-neutral level intended by Congress. Throughout the process, HCFA received more than 100,000 letters as a result of the federation of organized medicine's call to action. The November 25, 1991, publication of the final rule demonstrates the impact political involvement can produce. The conversion factor was restored to 95 percent of the original figure, representing a $10 billion increase for physician payments over the five-year phase-in period of the program. The State Society's attention will now be directed towards changing other negative aspects of the plan as they become apparent. Program implementation began January 1, 1992.

Laboratory regulations

The Society is presently awaiting publication of the final form regulations for the Clinical Laboratory Improvement Amendments of 1988 (CLIA 88). These regulations will govern certification requirements for all labs that examine human specimens, including labs in physicians' offices. Like RBRVS, CLIA 88 has also generated a great deal of physician response.

A legislative recap

Over the past year, the opportunity to convey the Society's position before a number of legislative committees was carried out by Society Past-President Gordon K. MacLeod, MD. During his term as president, Dr. MacLeod testified before the House Health and Welfare Committee on a number of issues, while also addressing the House Republican Policy Committee highlighting organized medicine's concern on a wide range of health care proposals. Continuing this practice, Society President Robert N. Moyers, MD, has appeared before the Senate Banking and Insurance Committee and the House Insurance Committee to testify on the new auto insurance law.

Although indigent care, workers' compensation, and living will initiatives have captured the top spots in the current legislative agenda, a number of other proposals are awaiting consideration. Here is a glimpse of some of these bills:

Auto insurance regulations: The Automobile Insurance Reform Act (ACT 6) became effective April 1990. The Act limited reimbursement of health care services provided to the victims of auto accidents to 110 percent of the Medicare allowance for such services.

The Society brought suit to attack the basis of the law. Its legal challenge is still ongoing, with a decision by the Commonwealth court expected in the near future. Efforts were also undertaken to seek interpretation of the regulations which were inplemented to carry out the intention of the law.

Numerous meetings between the Society and the Insurance Department focused on problems brought to the Society's attention by member complaints. Clarification of application of the law was also necessary. The Society commented extensively during the development of the regulations, and significant changes were achieved as a result of our actions, especially in safeguards related to utilization review by auto insurers.

The Society will continue to pursue corrective legislation and refinements to regulations, which went into effect on November 30, 1991, to lessen the negative impact of the law on the delivery of health care to auto accident victims.

Optometry: House Bill 1400, which would revise the optometric licensure law, did not pass the current sunset process. The Society opposed passage of this bill, since it could have been amended to expand the scope of practice for optometrists to include the prescribing of therapeutic drugs. Our policy is to support passage of a bill or resolution to extend the optometric law as it presently exists.

Childhood immunization: In coordination with the Pennsylvania Chapter, American Academy of Pediatrics, the Society supports House Bill 536. The measure, which mandates that all commercial insurance carriers cover children's immunizations, has passed the House and is now delayed in the Senate.

Pronouncement of death: House Bill 344, now on the governor's desk, was originally introduced to restrict the power of physicians to certify the death of a relative. Wide media coverage drew attention to a Western Pennsylvania case which involved such an incident and illegal drugs. Subsequent amendments to House Bill 344 will permit nurses to pronounce death with limits, such as when a physician is not able to be present within a reasonable length of time. However, under this bill, nurses could only pronounce death, not certify the cause of death.

HCFA Form 1500: Efforts to require all commercial insurance carriers to use the HCFA Form 1500 have been supported by

the Society under Senate Bill 969. This change would streamline the volume of paperwork now required of physicians by insurance carriers. Unfortunately, the bill's impact would not go beyond private health insurance carriers. The measure has passed the Senate and was placed on the House calendar for future consideration.

State Board of Medicine: Legislation intended to provide certification and regulation for respiratory care practitioners was amended with language that would change the make-up of the State Board of Medicine. Under the amendment, full voting power on the board would be provided to the three professions presently certified by the medical board and a respiratory care practitioner. This change would shift the majority vote of the board to non-physicians. Amendments to either remove these changes or correct them in another manner are being pursued.

Secretary of Health: This measure would remove the requirement that Pennsylvania's secretary of health be a physician. Although efforts to enact this change began last session, thus far the Society has been successful in prohibiting its passage. The bill remains on the Senate table.

Nominations: As of this writing, the governor has nominated Allan Noonan, MD, as secretary of health and Karen Snider as secretary of public welfare. Questions have been raised with regard to the Health position, potentially holding that nomination until regular session resumes on January 21, 1992.

The year ahead

The coming presidential election year will be a pinnacle year for those involved in the legislative process. As legislators begin putting the final touches on re-apportionment and start focusing on the 1992-93 fiscal budget and the November election, the political agenda will certainly prove to be a "free-for-all" for a number of special interest groups.

As a group interested in the health and welfare of all Pennsylvanians, organized medicine is well poised to be part of the political agenda as the General Assembly again considers such proposals as indigent care, workers' compensation, and living wills. In addition to care for the medically indigent, the Society's Board of Trustees has also identified tort reform and third-party reimbursement as priority issues.

The Society must continue to focus on the continuing efforts of non-physician practitioners (optometrists, podiatrists, psychologists, and physical therapists) to expand their scopes of practice. To date, these fronts have been well maintained. However, the process of legislating is one that never ends. Physicians must continue to remain alert and respond quickly to those proposals which may threaten or mandate how they practice medicine.

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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

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Indications: Yocon® is indicated as a sympathicolytic and mydriatic. It may have activity as an aphrodisiac.

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Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

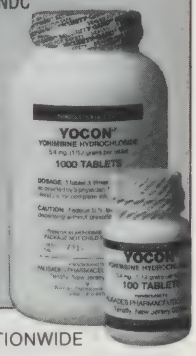
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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RBRVS ENACTMENT PROMPTS NEW E/M CODES

The new year brought many changes to how physicians are paid by Medicare and how those payments are determined. Included is the implementation of a new Medicare coding system for evaluation and management (E/M) services such as visits and consultations.

The previous Current Procedural Terminology (CPT) E/M coding system, used prior to January 1, 1992, was often criticized as being too subjective and susceptible to varying interpretations of the correct code. The new resource based relative value scale (RBRVS) system, however, cannot accomodate such variations because payment inequities would result. Thus, a new coding system was developed to accompany RBRVS.

The new system is quite different from the old system, although, like the old, it divides services by category, sub-category, and level. The new system uses *uniform content descriptors*, which are broken down into six specific components: 1) the extent of the history, 2) the extent of the examination, 3) the complexity of the medical decision making, 4) the extent of the counseling, 5) the extent of the coordination of care, and 6) the nature of the presenting problem. The principle difference is that the new system abandons the *short content descriptors* (e.g., brief, intermediate) used in the old system to differentiate among levels of service within a category or sub-category and substitutes a fundamentally different approach.

In addition to definition and criteria changes, the new system introduces an intra-service time for many of the codes. The time factor is defined as face-to-face time for office and other outpatient visits, as well as unit/floor time for hospital and other inpatient visits. It is used as a controlling or key factor only when counseling and/or coordination of care dominate (more than 50 percent) the intra-service encounter. The new system also emphasizes proper documentation of medical records. Medicare has developed a national, standardized program to be utilized by its carriers in monitoring the use of the new E/M codes. These objective criteria make it necessary to include adequate documentation of the visit.

Pennsylvania Blue Shield mailed educational information to physicians about the new E/M coding system in December 1991. The Society has prepared a supplemental publication entitled, "Evaluation and Management Coding System Analysis," which was advertised in the November/December *Executive Report*. The State Society urges all physicians to purchase the 1992 CPT book, which contains the codes.

The Health Care Financing Administration has allowed a 31-day transition period ending January 31, 1992, for implementation of the new codes. During the transition period, physicians may use the old codes *OR* the new coding system. Physicians who use the old codes will be paid at 1991 payment levels with no update. Those who use the new codes will be paid based on the 1992 fee schedule.

The State Society is offering a series of CPT coding seminars in late January and early February. For dates, locations, and registration information, see page 30. Any other questions should be directed to the State Society's Department of Medical Economics at 1-800-228-7823.

BLUE SHIELD DEVELOPS NEW MANAGED CARE PROGRAM

The State Society has contacted the Department of Health with concerns about Pennsylvania Blue Shield's new preferred provider network, BlueChoice. Blue Shield says the new managed care program is intended to provide flexibility to patients and competitive payments to physicians through fee-for-service reimbursement under a gatekeeper concept.

As originally proposed, the program allowed employers two gatekeeper options. The first, the "passive gatekeeper" approach, would allow subscribers to choose from a panel of primary care physicians. The second, the "designated gatekeeper" approach, would require subscribers to choose one primary care physician.

The Society has concerns that safeguards against risks of insufficient access and underutilization are not clearly defined in the new program. In its recommendations to the Department of Health, the Society suggests BlueChoice should maintain primary care participation levels at least as high as are required and exist in health maintenance organizations (HMOs) operating in the plan service area.

The State Society also criticized:

- The open-endedness of the provider contract terms;
- The lack of an adequate quality assessment program;
- The program's efficiency evaluation system, which appears to rate physicians' efficiency based solely upon their utilization rates without reviewing whether their utilization was appropriate; and
- Blue Shield's plans to exclude physicians without case-by-case review by the Department of Health.

The Society further contends that physicians who already signed BlueChoice contracts should have the opportunity to withdraw according to the outcome of program approval, and new signatures should be required after program changes and approval occur, allowing physicians to make an informed choice whether or not to participate.

At this time, the Department of Health has approved the program for marketing under the following provisions: 1) Blue Shield must resubmit the package utilizing only the passive gatekeeper approach, 2) Blue Shield must provide information to subscribers and providers explaining the passive gatekeeper approach, and 3) Blue Shield must limit differentials between in- and out-of-network enrollee reimbursements to 20 percent.

CAT FUND APPROVED AT 90 PERCENT

The state Insurance Department approved the physician CAT Fund at 90 percent for 1992. The percentage, which fluctuates each year, is a surcharge to basic malpractice insurance premiums and serves as insurance above the amount covered under basic plans. In 1991 the CAT Fund premium was set at 68 percent.

The jump in percentages is based on two factors this year. First, claims paid in 1990 were higher than those paid in 1989, which forced insurers to dip further into the fund than anticipated. Also, this year's premium base has decreased, which will reduce primary rates.

SELECTIVE CONTRACTING UNDER CONSIDERATION

The Pennsylvania Department of Public Welfare (DPW) may introduce a new system of Medicaid reimbursement to Pennsylvania hospitals in the form of selective contracting. To date, only three

states—Illinois, California, and Washington—have initiated such a program.

Selective contracting is a program in which providers bid competively to be an exclusive service provider. Such a program will, according to DPW, accomplish two goals: 1) save money, and 2) help the Department gain more administrative control. DPW staff suggested that since the program probably would not be beneficial statewide, it most likely would be implemented only in the Pittsburgh and Philadelphia metropolitan areas, and other selected areas of the state.

This system is under State Society scrutiny because of concerns about access and continuity of care, a possible disproportionate distribution of the Medicaid burden, and eventual effects on the financial viability of excluded hospitals. While selective contracting has been used in the private sector for managed care programs, it is a relatively new approach for setting Medicaid reimbursement rates.

Developmentally, DPW's proposal appears to be in its embryotic stages, with implementation targeted for July 1993. The Department has formed an internal staff work group and plans to hire a consultant to develop the proposal. Recognizing physicians' concerns, the Department has indicated plans to form an external work group of representatives from various Medical Assistance Advisory Committee subcommittees including the Medical Subcommittee. The State Society is considering this option and other mechanisms for providing input, and its Council on Medical Economics continues to follow the issue closely.

OMBUDSMAN PROGRAM TO ASSIST BILLINGS

The State Society, along with the Department of Public Welfare (DPW), is addressing problems for physicians with Medical Assistance (MA) reimbursement.

The Medicaid Ombudsman Program is a cooperative effort between the Department of Public Welfare (DPW), the State Society, and county medical societies. The program was designed to help physicians and their office staffs address billing, policy, and enrollment questions. Due to budgetary limitations and staff reductions at DPW, access to such information has been a problem.

The program was developed to reduce the hassles associated with the MA Program by training county medical society executives. Ultimately, an MA reimbursement training seminar is provided in the county for providers' office staffs. The costs associated with the program are jointly shared by DPW and the county. The State Society serves as liaison between DPW and the county society and provides assistance when problems occur.

The success of a pilot program in Lackawanna County, headed by Patricia A. Martin, county executive, has prompted an expansion of the program. Allegheny and Beaver counties were trained in December, and training seminars for office staff will be held in the first quarter of 1992. County executives may receive additional information about the program by calling the State Society's Department of Medical Economics at 1-800-228-7823.

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An Open Letter To Magic Johnson

George J. Pazin, MD

The last installment in this series dealt with post-test counseling of a person whose HIV test was negative. The plan was to provide counseling for an HIV-infected person in this installment. NBA basketball star Magic Johnson's surprise announcement on November 7, 1991, of his infection with HIV has provided an unexpected opportunity to counsel a well-known person through an "open letter."

This is part of a continuing series entitled, "Transforming AIDSpeak into AIDSense."

Dear Magic: I listened with interest to news reports of your November 7, 1991, press conference. As a specialist involved in clinical research studies of HIV infections, I was deeply disappointed to hear that you had acquired infection with HIV. On the other hand, as an educator involved in teaching high school students, the general public, medical students, physicians, dentists, nurses, and lawyers about AIDS and infection with HIV, I was pleased to hear that you wished to become a spokesperson for HIV/AIDS education. Acquiring infection with HIV, however, does *not* automatically confer to you immediate HIV/AIDS-educator qualifications.

If you truly wish to promote AIDS education, you must become educated on this subject so you can answer questions thoughtfully, sensibly, and accurately. Becoming well educated will also benefit you personally. Unfortunately, many well-intending HIV/AIDS educators and infectious disease specialists are not completely truthful when dealing with difficult issues of HIV transmission with patients and the public. Instead, we HIV/AIDS educators often try to say things in a nice way to spare patients the anguish of dealing with the troublesome, unpleasant aspects of HIV infections and AIDS.

The first fact you need to learn is that there is such a thing as *safe sex*, but contrary to your belief, it is not simply using a condom and spermicide. Safe sex is any sex in any body orifice without any contraceptive barriers with an *un*infected person. The best you can do if your partner is HIV infected is *perhaps* make sex *safer* with proper use of condoms and spermicide, but that does not make sex *truly safe*. If you wish to promote more widespread condom usage, you should refer to that as "safer sex."

I should re-emphasize that there is such a thing as safe sex, e.g., *sex with uninfected partners*, which is most easily accomplished within faithful, monogamous relationships. You mentioned on the Arsenio Hall show that you want to bring HIV/AIDS education to the Black community. I suggest that you bring the message of *truly safe sex*, as well as safer sex, to the Black community.

There is a religious saying that if someone needs bread, do not give them a stone. If someone needs to be informed about the wisdom of truly safe sex (risk elimination or confining one's sexual intimacy to an uninfected partner), it is unfortunate if you only tell them of risk reduction. I hope that you are able to rise to this higher level of education.

The next, more difficult issue we need to address is whether you should or should not continue to be sexually intimate with your wife or any other woman. Since the so-called "protection" provided by condoms and spermicides is likely not complete, and this is an eventually lethal infection, I suggest that harsh realities require you to confine yourself to intimacy which precludes direct, moist lining surface exchange of any body fluids which may contain HIV. These fluids include blood, semen, and saliva. (HIV-infected women also have to be concerned about direct lining surface exchange of vaginal secretions.)

I am well aware that some HIV/AIDS educators, such as the Pennsylvania Public Health Association, say there is no evidence of spread of the AIDS virus by saliva, but *absence of evidence* is not *evidence of absence* of spread via saliva. Conditions of most epidemiologic studies do not enable the investigators to detect spread of the AIDS virus via saliva, but that does not mean it does not happen. It is just not recognizable. In fact, an informal survey of about a dozen infectious disease specialists revealed that none were willing to passionately kiss HIV-infected persons.

Since the AIDS virus has been found in

". . . there is such a thing as safe sex, but . . . it is not simply using a condom and spermicide."

Dr. Pazin is an infectious disease specialist and associate professor of medicine at the University of Pittsburgh School of Medicine.

saliva, since the mouth has been the portal of entry of HIV during breast feeding and oral sex, since saliva is directly exchanged lining surface to lining surface during passionate kissing, since epidemiologic studies do not enable us to study nor *exclude* this route of spread, and since we are dealing with a terribly serious infection, common sense says we should not play games with passionate kissing as a route of spread. Some investigators have found that incubating the AIDS virus for 60 minutes in saliva seems to inhibit the virus, but I do not feel these studies exclude transmission via saliva. Remember, we are able to culture (grow) HIV from saliva. Therefore, difficult as it may seem, I do not believe we should ignore this threat. The consequences of spread to your lover are too serious to ignore.

A simpler issue that needs addressed is whether you need to take any special precautions regarding casual or close personal contact with friends or acquaintances. Fortunately, the risk of spread via casual contact seems to be too small to measure in household exposure studies. In a dozen such studies of 890 uninfected persons living with 497 persons with AIDS, no accidental spread to non-intimate contacts occurred.

This is good news inasmuch as you don't need to constantly fear accidentally spreading the virus to family or friends. However, this does not mean that you should be careless and cavalier. I suggest that you not directly share straws, glasses, or eating utensils. Simple cleansing of eating utensils between use is sufficient to eliminate the risk of spread in this manner. I also recommend simply rinsing off glasses that might be shared by others. Don't worry about water fountains, but you should not share toothbrushes or razors.

My final point relates to the sexual contact who might have *infected you* and sexual contacts who might have been *infected by you*. Do you, Magic, recommend that any of your sexual partners get tested for infection with HIV? I have heard that you had a negative test in 1988. If so, I suggest that you publicly invite your sexual contacts since 1988 to get tested so that, if infected, they may also benefit from early intervention therapy and take measures to avoid spreading the virus to others. In general, it is advisable for more persons to get tested for personal, as well as societal reasons.

Before ending, I wish to relay to you one more important piece of information which many people have not learned despite several years of educational efforts involving hundreds of millions of dollars. A few days ago, during an AIDS educational session, I asked the audience, "What is the meaning of a *confirmed, unequivocally positive* test for antibodies to HIV in an adult?" Two answers were provided.

1) The confirmed positive test means that the person is *infected* with HIV, *infectious* to intimate or needle-sharing contacts, and *at risk* of having or developing AIDS in the future.

2) The confirmed positive test means the person has been *exposed* to HIV, *may or may not be* infected, *may or may not be* infectious, and *may or may not be* at risk of having or developing AIDS in the future.

Unfortunately, as expected, half the attendees indicated that they thought the second was the answer; the correct answer is the first. It is important that everyone understand that the HIV-positive person is HIV infected and has not just experienced a "close call." The person has been exposed, inoculated, *and* infected with HIV.

One does not develop specific antibodies to HIV merely by being exposed to the virus; the person has to become infected with the virus to develop antibodies. I am sorry to have to be so emphatic, but it is important for people to understand the precise meaning and implications of being HIV positive.

I hope this open letter assists you in learning more about this infection so that you might more responsibly carry out your HIV/AIDS educational goals. I would be happy to communicate more with you if you have any specific questions pertaining to your infection and your concerns for others.

P.S. After I had originally written this letter, I heard that you had changed your teaching regarding safe sex and were promoting abstinence as the only way to achieve truly safe sex. I am delighted to hear you have made that change.

I also read in one of the scandal sheets that you avoided sexual intimacy with your wife during your Hawaiian vacation in order not to infect her. While unfortunate, this is appropriate behavior since it would be especially tragic to transmit the HIV virus to your pregnant wife, who may well not be infected presently. Also, I presume that your physicians have suggested that it might be useful to have your wife tested with the polymerase chain reaction (PCR) test to try to determine more quickly whether she has become infected.

"It is important that everyone understand that the HIV-positive person is HIV infected and has not just experienced a 'close call.'"

STATE MEDICAL BOARD CONSIDERING HIV/HBV POLICY

The Pennsylvania State Medical Board is considering, but has not endorsed, a formal policy statement of the Federation of State Medical Boards on the prevention of HIV/HBV transmission to patients.

The policy was adopted by the Federation's Board of Directors in October and states the following:

- Physicians should comply with the Centers for Disease Control (CDC) guidelines for preventing the transmission of HIV/HBV to patients;
- Physicians who are infected with HIV/HBV should not perform exposure-prone procedures as defined by CDC, except within guidelines set by the state medical board;
- The state medical board should require physicians doing exposure-prone procedures to know their HIV/HBV status, require reporting of HIV/HBV-infected physicians to the state medical board and ensure confidentiality of those reports, and establish practice guidelines and monitor the practices of HIV/HBV-infected physicians; and
- The state medical board should be authorized to discipline physicians who violate the statute(s) or rule(s) related to preventing transmission of the infections to patients.

The Pennsylvania Public Health Association (PPHA) has adopted the CDC policy with one major exception. PPHA believes that notification of physician infection should not be required, labeling it unnecessary and improper.

The State Society opposes the CDC guidelines on HIV/HBV prevention and reporting for similar reasons, and the guidelines counter the Society's current policy. Pennsylvania Medical Society leaders have expressed their concerns to the Pennsylvania State Medical Board and are awaiting a final position statement.

OSHA ISSUES FINAL BLOODBORNE PATHOGENS REGS

The Occupational Safety and Health Administration (OSHA) has issued the long-awaited final regulations on protective requirements for employees exposed to blood in their routine work. According to OSHA, the preventative measures will reduce on-the-job risks for employees and is expected to "prevent more than 9,200 infections and 200 deaths per year."

The regulations, published in the December 5, 1991, *Federal Register*, become effective March 5, 1992, and cover provisions for employees of physician offices, hospitals, nursing homes, and other ambulatory health care settings. Included are strict requirements for the completion of exposure control plans and the provision of initial information and training, as well as other measures.

OSHA estimates the cost of implementing the new guidelines, which will affect approximately five million workers nationwide, at $821 million per year. For physicians, however, abiding by the rules is *extremely important* for employee safety. Additionally, violation of the guidelines could result in a fine up to $70,000 per incident.

The Pennsylvania Medical Society is planning a number of efforts to educate physicians about these regulations. For a copy of the regulations, call the Society's Department of Educational and Scientific Affairs at 1-800-228-7823.

FINAL CLIA REGS DUE

This month the Health Care Financing Administration (HCFA) is scheduled to release regulations to implement Clinical Laboratories Improvement Amendments (CLIA). The regulations will require physician office laboratories and other testing sites to meet federal regulations.

The Commission on Office Laboratory Accreditation (COLA), founded by the American Medical Association (AMA), will help physicians prepare for CLIA evaluations. Also, COLA will apply to HCFA for a "deemed status," so that laboratories accredited by COLA will be accepted as meeting federal standards.

PENNSYLVANIA MEDICINE will publish the final CLIA regulations when they are released.

AIDS PROGRAM PLANNED

The State Society, in cooperation with Penn State and the Pennsylvania Department of Education, is planning a train-the-trainer session focusing on AIDS education. The program will be held in late January or early February at Penn State Harrisburg in Middletown.

The public affairs program is geared toward school administrators and teachers; it will help equip them with information needed to address AIDS issues in the school setting. Depending on the success of the Harrisburg program, similar sessions may be scheduled at other Penn State campuses in the future. For information, call Penn State Harrisburg at 1-800-346-0319.

TASK FORCE ADDRESSES MALTREATMENT OF CHILDREN

The State Society and the Pennsylvania Bar Association (PBA) have joined forces to fight maltreatment of children in the Commonwealth. The Joint Task Force convened as a cooperative effort to fight this public health problem facing Pennsylvania, as well as the nation. Included in that arena are child abuse and violence, the refusal of care for children for varying reasons, and the neglecting of children's needs.

One key goal of the Task Force is to provide a forum for the exchange of expertise between physicians and lawyers. A second major goal is to look cooperatively at Pennsylvania laws and try to update and change those which the Task Force believes need adjustment.

A second meeting of the Task Force was scheduled for early January to discuss the next group action.

SMOKEOUT PARTICIPATION CAUSES CONTROVERSY

In recognition of the American Cancer Society's Great American Smokeout in November 1991, the Pennsylvania Medical Society, in cooperation with the Pennsylvania Pharmaceutical Association, instituted a recognition program encouraging pharmacists to stop selling tobacco products; but tobacco industry representatives have taken offense.

According to an article which appeared in the *Pittsburgh Post-Gazette*, Thomas Lauria, spokesperson for the Tobacco Institute in Washington, DC, calls the Society's efforts "coercion." The Society, however, feels its efforts are worthwhile. The program—the only statewide effort of its kind in the nation—began by recognizing those Pennsylvania pharmacies which had stopped selling tobacco. In the initial phase, more than 60 pharmacies throughout the state were honored with certificates of recognition.

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Recouping Past-Due Charges

The Health Care Group

Last month we discussed how to establish and maintain a time-of-service payment policy; and we stressed the need for a comprehensive, written collection policy to follow when immediate payment is not made. This month, we describe a collection system to recoup past-due charges.

The region's continuing recession means patients will be slower in paying doctors' bills. This situation underscores your practice's need for a consistent, effective collection policy. The following guidelines will help you develop such a program.

Keep collections in-house

Recognize that a good in-house collection system will produce much better results than a collection agency. In fact, we recommend you use collection agencies only as a last resort. Agencies can charge as much as 50 percent of whatever they collect. Why pay that, when a clear collection program will give your staff a good chance to collect 100 percent?

Two elements are indispensable to an in-office collection system. First, assign one specific employee to manage the collection process for all outstanding patient accounts. Being accountable, that person will follow the collection routine to its conclusion and retrieve more dollars for the practice than would someone irregularly assigned to the task. That employee needs regularly allotted time to work on accounts and a quiet area away from the front desk to ensure confidentiality when making calls.

Second, institute a tracking system, noting where each delinquent account stands in the collection process. The easiest system is to use a 3 x 5-inch card file box with dividers for the days of the current month and the following month. When a patient is first contacted about an overdue account, the name and other information is placed on a card and filed for follow-up on the appropriate day. Each reply the patient gives is also recorded, providing a record of all responses. (Each piece of information can also be recorded on a computerized collections system.)

Making contacts

The basic collections routine can be tailored to a practice's particular needs, but must be strictly enforced. An effective collections system uses both telephone calls and preprinted letters. Personalized letters are far more effective than stickers and handwritten warnings on monthly statements. The telephone is successful because it provides personal contact during which the patient's cooperation can be elicited.

In a collection schedule which uses both letters and calls, timing is an important factor. For example, calling all patients with slightly past-due bills is too time-consuming and ineffective. And many patients feel insulted if they intend to pay and there has been only a slight delay. However, a telephone call can work well if made at the proper time and before a patient's intent not to pay has developed. The blend of firmness and friendliness is also important to the outcome.

Likewise, this system uses a cordial but increasingly firm series of letters. Use "master" letters stored on your word processor, simply typing in each patient's name and address. This system makes collections routine and businesslike, and calls for no physician involvement.

Keeping collections in good shape requires organization, tact, and consistent effort. Establish a comprehensive, written policy, and entrust it to a personable, well-trained staffer. These days, no practice can afford to automatically write off any account.

The contributing authors, Patricia M. Salmon and Edward L. Grab, are consultants with The Health Care Group, a practice management consulting firm in Plymouth Meeting.

SUGGESTED COLLECTION SCHEDULE

1. 45 days after 1st bill: Letter #1—A gentle reminder. Say you haven't heard from patient in response to statements sent: ask whether patient has any questions, inviting them to call if so, and request to hear from them soon.

2. 66 days (three days after the patient should have received the 60 days' bill): Telephone call.

3. 90 days: Letter #2—State payment not received despite statements, letter, and telephone call. Request patient contact you by a specific date about payment.

4. 120 days: Letter #3—State account is now three months past due, and, regrettably, must be sent to collection agency if payment not received in 10 days.

5. 125 days: Telephone call (very firm, merely to remind that account is going to collection if payment not received).

6. 135 days: Send to collection agency. Remove account from current file and place in file marked "At Collection."

Schedule for telephone promises

If payment promised by telephone fails to arrive, follow this schedule:

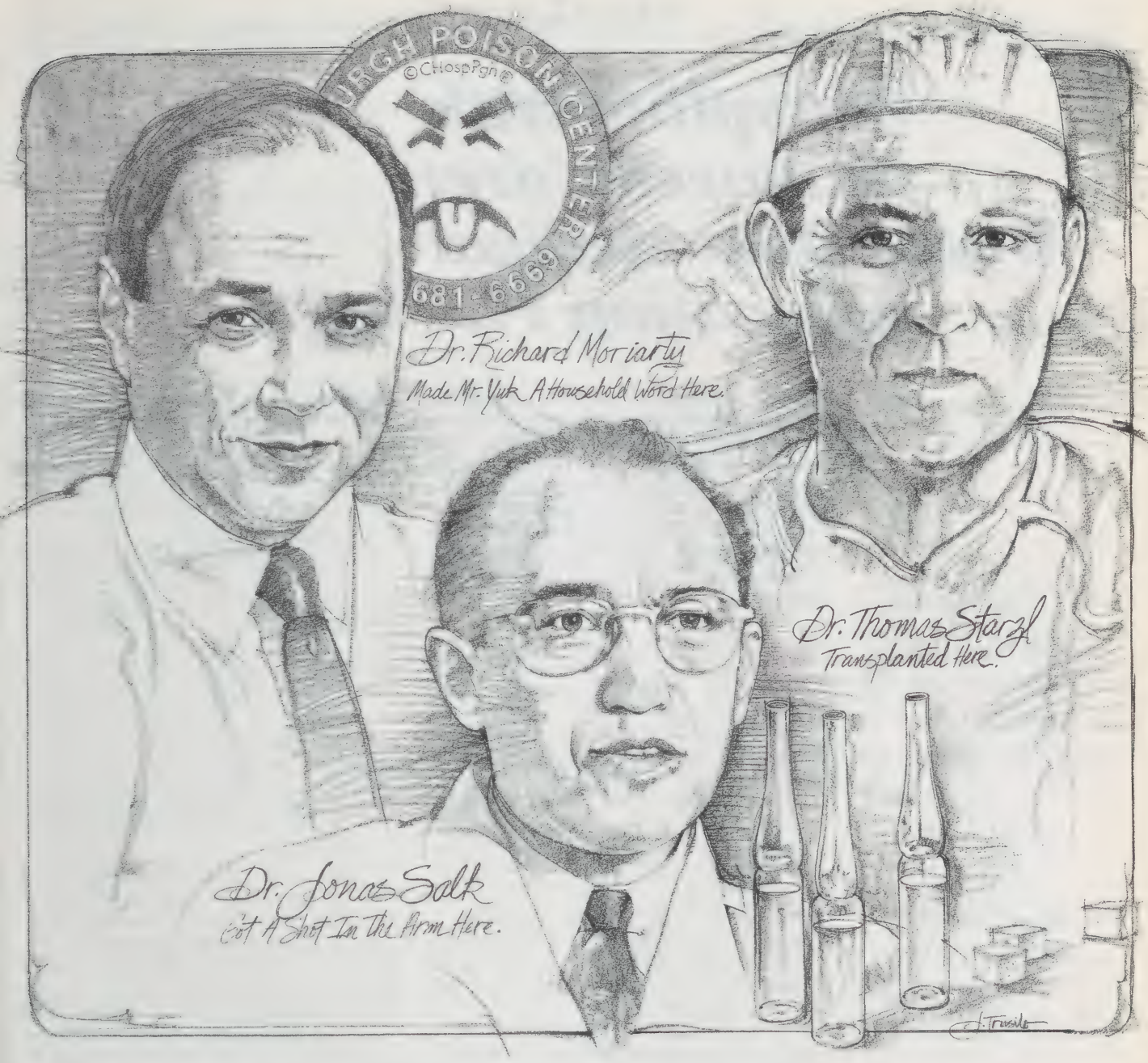
(1) 3 days after promised payment date: Telephone call to remind patient of promise.

(2) 10 days after promised: Letter #4—Remind patient that in your telephone conversation, payment was promised by a date you both agreed on, as the practice record shows, but no payment has been received. Request to hear from patient soon, as they promised.

(3) 30 days after promised: Letter #3 (above).

(4) 35 days after promised: Telephone call (very firm). (Note: If patient makes a second promise, repeat this procedure; however, do not accept a third promise.)

(5) 45 days after promised: Send to collection agency.



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Grappling With Managed Care: Where Does Medical Education Fit?

John J. Whyte
Michael D. Cantor

While the effects of managed care on access and quality have been extensively debated, the implications of these efforts on medical education have not been widely explored. Because managed care will increasingly impact upon medical education, now is an opportune time to examine its effect and to discuss the need for medical students to be aware of managed care principles.

The primary setting for medical education, the hospital, is changing. In recent years, hospitals have attempted to reduce costs and/or maximize reimbursement by increasing outpatient services. As a result, the patient's principal diagnosis and work-up are frequently performed prior to admission, and much of the recovery takes place after hospital discharge. Such a system not only risks disruption in the continuity of care, but potentially affects medical education. It denies medical students and residents the opportunity to see the full spectrum of illness and instead limits them to treating acute conditions.

A major change in the insurance industry, with subsequent changes for medical education, has been the development of managed care plans. The growth of managed care plans offers a unique opportunity for medical students to broaden their medical education, since such plans offer an ideal setting for students to gain ambulatory care experience. Many health maintenance organizations (HMOs) and managed care plans focus on primary care and prevention, in marked contrast to the tertiary care to which most students are exposed in the hospital. However, the role of such health plans in medical education has been minimal, with the exception of those HMOs either owned by or closely associated with a university hospital. This lack of involvement is due mainly to the interest in containing costs. Most HMOs and managed care plans perceive teaching as a loss of productivity, arguing that medical students and residents slow down the process, thereby increasing costs. Given today's competitive market, few are willing to venture into an area that is not proven to increase revenue or reduce costs. In addition, many HMO physicians have little, if any, interest in teaching.

Despite the common belief that medical education leads to inefficient and costly uses of resources, numerous recent studies challenge this assertion. Buchwald, et al. investigated whether indirect costs are higher early in the training year when house officers might be less efficient—the so-called "July phenomenon."[1] Using analysis of covariance to correct for age, sex, diagnosis-related group, urgency of admission, temporal change, and mortality, they found no differences in length of stay, total charges, or categories of ancillary charges.

A more recent study examined whether medical education increases costs in teaching hospitals by causing longer lengths of stay and greater resource use.[2] After adjusting for severity of illness and demographic characteristics, patients on the teaching services had a shorter length of stay, a lower mean charge, and fewer procedures than for those patients on the non-teaching service.

These studies have important implications; they demonstrate that medical students and residents do not necessarily increase the cost of medical care. As a result, cost-containment attempts aimed at medical education need to be reevaluated, as they may have serious effects.

Given the need for medical students to learn managed care principles and the increasing practice of medicine in managed care and ambulatory settings, medical educators need to provide these experiences. Managed care providers need to reassess the reasons for their lack of involvement in medical education.

Teaching may actually reduce costs and improve the quality of care. The academic environment fosters creative ideas and new approaches to common problems.

The authors are medical students. John Whyte is enrolled in an MD/MPH program between Hahnemann and the Harvard School of Public Health. He serves as vice chair of the State Society's Medical Student Section. Michael Cantor is enrolled in an MD/JD program at the University of Illinois.

Such an environment challenges everyone, not just residents, to improve their clinical skills.

Attempts at cost-containment also have an effect on physician hiring. While current physician hiring is based mainly on residency evaluations, board scores, and letters of recommendation, in the future hiring will hinge on the physician's ability to deliver high-quality care as defined by practice parameters. This concept of "selective contracting," where employers hire physicians based on previous performance and utilization data, is already playing an important role at certain companies.

At U.S. Healthcare (USHC), one of the country's largest HMOs, Hyman Kahn, MD, senior vice president, sees a need for physicians to be aware of managed care principles. He tells newly selected participating physicians that USHC "does not own you, but we want you to practice within the system and know what the rules are."

The current USHC application asks physicians about their previous managed care experience and if they believe in the managed care philosophy. Approximately 25-30 percent of applications are denied annually due to a conflict in philosophy towards patient care.[3]

Robert B. Edmiston, MD, senior vice president for professional affairs at Blue Shield of Pennsylvania, sees managed care and selective contracting as the two most important issues for insurers over the next 10 years. Dr. Edmiston notes that the best way to control costs is to put managed care guidelines in place and to make certain that they are followed. He believes that if insurers can hire only those physicians who already tend to practice within managed care guidelines, it will be easier for insurers to control costs. At the same time, other physicians will be forced to adopt managed care principles if they wish to maintain their patient population. For its BlueChoice Preferred Provider Program, Blue Shield is rejecting approximately 30 percent of physicians who apply. Included in the factors for selection are board certification and the amount of Blue Shield dollars per enrollee that the doctor has billed in the past.

This emphasis on physician behavior as a hiring criterion will, no doubt, continue to increase. Medical students and residents need to be educated early concerning these principles if they wish to maximize their employment opportunities.

The current medical school curriculum must adapt to the changing practice of medicine. Students need to learn about the environment in which health care is delivered. To assume that students can learn the economic, political, ethical, and social issues of health care as a type of on-the-job training is a disservice to all involved.

Students need to be taught how to practice in managed care settings—most likely the future modality of health care delivery. The basic premise of managed care is a good one: coordination of care to limit inefficient and inappropriate medical care. There is nothing inherently superior in a fee-for-service system. Although incentives do exist in managed care settings to reduce the use of services, they also exist in the fee-for-service system to provide unnecessary services. The interest in practice parameters is an attempt to reduce any such incentives/disincentives.

Today's medical students will ultimately be running the medical establishment. Thus, it is important for them to understand managed care as early as possible so they can help transform cost-containment efforts into appropriate, high-quality medical care acceptable to both physician and patient.

"Medical students need to be taught to practice in managed care settings — most likely the future modality of health care delivery."

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Learning Generics

David J. Shulkin, MD

The growing use of generic drug substitution may have important implications on quality of care. This study was conducted to determine resident physicians' knowledge of restrictive prescribing policies at the hospitals where they primarily practice.

In May 1991, the Pennsylvania Medical Society Resident Physician Section distributed a questionnaire to physicians-in-training asking about their knowledge of generic substitution policies. A total of 82 questionnaires were distributed to resident physicians at six Pennsylvania teaching hospitals. Seventy-one questionnaires were returned, of which 63 were properly completed and usable (a 77 percent response rate).

A pharmacist at each of the six hospitals was contacted by phone to determine if, in fact, a policy of generic substitution was in effect. Forty-seven percent of resident physicians did not know whether their hospital had policies of generic substitution. All remaining residents believed that such a policy was in existence. There did not appear to be significant differences in residents' responses when stratified by hospital site, type of specialty training, or year of post-graduate training. Results from a phone survey with pharmacists suggested that all six hospitals did indeed have active policies of generic substitution.

The high percent of resident physicians that were unaware of their hospitals' policies on generic substitution is suggestive of poor communication between house staff and the hospital pharmacy. Such a finding is not isolated. Surveys of managed care organizations show that the majority of pharmacies do not notify physicians of substitutions on formularies,[1] therefore making it difficult even for the physician who is aware of the formulary to know what preparations are being dispensed to patients.

Hospital formularies and other administrative interventions have gained momentum in response to the rapid increase in the cost of prescription medications. While these policies are often very effective at reducing utilization,[2] most physicians are opposed to these restrictive policies, both out of concern for the impact on patient care and the challenge to autonomy.[3]

Unfortunately, educational programs which offer an alternative approach to address the efficient use of pharmaceuticals are rare in teaching hospitals.[4] Yet, those academic programs that have initiated education programs have had success in influencing physician prescribing habits by simply providing information on appropriate prescribing behavior.[5,6]

The lack of attention towards prescribing practices in the teaching environment may have both cost and quality implications. Resident physicians have been found to order more expensive drugs than their faculty.[7] In addition, by not devoting attention to presciption practices in our training programs, we may not be addressing the problem of prescription writing errors among house staff. In one study, medication errors were noted in 21 percent of all orders[8]; and in another study, although the error rate was significantly less, it was greatest among those with the least experience: the first-year, postgraduate residents.[9]

Resident physicians, as well as most other doctors, have a deep interest in minimizing the cost of patient medications and a concern about the drug's therapeutic effectiveness. This study shows that many residents were unaware of restrictive policies within their hospitals and therefore were also unlikely to be aware of the specific drug preparation being dispensed.

Improved communication between hospital pharmacies and house staff is needed; and strengthened educational efforts concerning efficient prescribing practices, as well as the therapeutic effectiveness of generic preparations, are warranted.

The contributing authors are members of the State Society's Resident Physicians Section: Angelo P. Giardino, MD, Thomas F. Freenock Jr., MD, Daniel S. Henriksen, MD, Craig Richman, MD, Mark S. Friedlander, MD, Steve M. Pandelidis, MD, and Terence J. Heywood, MD.

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UNFAVORABLE PROGNOSTIC FACTORS OF STAPHYLOCOCCAL INFECTIVE ENDOCARDITIS: EXPERIENCE IN A COMMUNITY HOSPITAL

James F. Reed, PhD; Charles Gordon, MD; Joanne Harcke

OBJECTIVE: Bacterial endocarditis in the elderly patient is recognized as a potentially life-threatening infection. This study was conducted to compare clinical and laboratory factors in staphylococcal endocarditis patients, and determine whether these factors or a combination of factors are predictive of a fatal outcome.

METHODS: Using specific diagnostic and demographic criteria for infective endocarditis, 48 patients were chosen for comparison. Clinical and laboratory statistics were recorded for each patient, and several methods of analysis were used to examine the data.

RESULTS: In this study the mortality rate was 10.4 percent, which is consistent with similar studies of this nature. Previous publications have identified six risk factors for a fatal outcome including age, known cardiovascular disease, prior hospitalization, neurological symptoms, the platelet count before therapy, and left-sided heart involvement.

CONCLUSION: While S. aureus endocarditis is recognized as a life-threatening disease, and the authors recognize that the power of the study may be limited due to the resticted sample size, evidence of survival of S. aureus septicemia in a community hospital is more favorable than would be expected.

For additional information or a copy of the complete study, contact James Reed III, PhD, at Lehigh Valley Hospital Center Department of Research and Publication Support, (215) 776-8000.

TOBACCO SMOKING IN STATE-OWNED PSYCHIATRIC HOSPITALS: REPORT OF A SURVEY OF PENNSYLVANIA HOSPITALS

Jaan Sidorov, M.D.; Victor Villagra, M.D.

OBJECTIVE: In response to the threats of cigarette smoking, many health care institutions have become smoke-free. However, similar efforts in psychiatric facilities have lagged since smoking is more prevalent among their patients. This survey was conducted to clarify the problem of tobacco usage among psychiatric inpatients.

METHODS: Officials of Pennsylvania's psychiatric hospitals completed a survey related to tobacco usage in their facilities. Respondents were asked to estimate average daily census, the percentage of smokers among their long-term patients, how cigarettes were purchased for patients who smoke, and whether a smoking-cessation program was available.

RESULTS: Ultimately, 100 percent of the officials of Pennsylvania's 14 psychiatric facilities completed the survey. The study confirms a high prevalence of smoking among the inpatients (62 percent). Cigarettes are available to all psychiatric patients across the state who want them, through a number of sources. Only three hospitals offered smoking-cessation programs, one of which was discontinued due to lack of interest.

CONCLUSION: The results indicate that smoking remains a threat to the health of this population, including non-smokers. Since this is the first survey to document information about smoking in this specific population, the authors feel further research is warranted.

For additional information or a complete copy of the study, contact Jaan E. Sidorov, MD, or Victor Villagra, MD, at Geisinger Medical Center Department of General Internal Medicine, (717) 271-6211.

ASPIRATION FOLLOWING ACUTE STROKE: A QUALITY ASSURANCE STUDY

Frederick B. Myers, MD

OBJECTIVE: Swallowing problems following acute strokes historically resolve within three months or result in nonfatal aspiration. In a few cases, however, aspiration pneumonia can occur leading to death. This study was conducted to determine signs, symptoms, and preventative treatments of aspiration pneumonia.

METHODS: All cerebrovascular accident (CVA) discharges over a five-month period were surveyed by discharge diagnosis using software and the personnel of a quality assurance department. Dishcarged CVAs without diagnosed pneumonia were reviewed for fever, and those with a fever were reviewed to determine if aspiration pneumonia was considered. Further comparison occurred to determine the effectiveness of using a plain chest x-ray versus videofluoroscopy in distiguishing aspiration.

RESULTS: Of 137 CVA discharges, 54 cases with fever were reviewed for aspiration pneumonia. Six percent of patients who developed fever after CVA were checked for aspiration pneumonia using a repeat chest x-ray, and none were evaluated for aspiration using videofluoroscopy. Further chart review revealed that aspiration was suspect due to noted secretion/swallowing problems. The mortality rate among the 54 patients was high (7.7 percent), but highest among those who had clinically developed secretion problems (46 percent). Also, the presence of the clinical triad of fever, chest pain, and cough separated patients with a high death rate from others.

CONCLUSION: Aspiration following stroke has been recognized as common and underestimated by clinical observation. Videofluoroscopy is superior and identifies a 50 percent chance of aspiration. At greatest risk are those patients with combined cerebral-brainstem strokes. The observation of dysphonia and its correlation with aspiration has not yet been found to exist. A multi-service, educational effort is needed to enhance medical and nursing staff response to this phenomenon.

For additional information or a copy of the complete study, contact Frederick B. Myers, MD, at (717) 288-8389.



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1. Data on file, Lilly Research Laboratories. *See accompanying page for prescribing information.* ©1991, ELI LILLY AND COMPANY NZ-2947-B-249304

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Brief Summary. Consult the package insert for complete prescribing information.

Indications and Usage: 1. *Active duodenal ulcer*—for up to 8 weeks of treatment at a dosage of 300 mg h.s. or 150 mg b.i.d. Most patients heal within 4 weeks.

2. *Maintenance therapy*—for healed duodenal ulcer patients at a dosage of 150 mg h.s. at bedtime. The consequences of therapy with Axid for longer than 1 year are not known.

3. *Gastroesophageal reflux disease (GERD)*—for up to 12 weeks of treatment of endoscopically diagnosed esophagitis, including erosive and ulcerative esophagitis, and associated heartburn at a dosage of 150 mg b.i.d.

Contraindication: Known hypersensitivity to the drug. Because cross sensitivity in this class of compounds has been observed, H_2-receptor antagonists, including Axid, should not be administered to patients with a history of hypersensitivity to other H_2-receptor antagonists.

Precautions: *General*—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests—False-positive tests for urobilinogen with Multistix® may occur during therapy.

Drug Interactions—No interactions have been observed with theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility—A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups.The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Worldwide, controlled clinical trials included over 6,000 patients given nizatidine in studies of varying durations. Placebo-controlled trials in the United States and Canada included over 2,600 patients given nizatidine and over 1,700 given placebo. Among the adverse events in these placebo-controlled trials, only anemia (0.2% vs 0%) and urticaria (0.5% vs 0.1%) were significantly more common in the nizatidine group. Of the adverse events that occurred at a frequency of 1% or more, there was no statistically significant difference between Axid and placebo in the incidence of any of these events (see package insert for complete information).

A variety of less common events were also reported; it was not possible to determine whether these were caused by nizatidine.

Hepatic—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

CNS—Rare cases of reversible mental confusion have been reported.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to nizatidine. Impotence and decreased libido were reported with similar frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic—Anemia was reported significantly more frequently in nizatidine than in placebo-treated patients. Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H_2-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental—Urticaria was reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity—As with other H_2-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. The ability of hemodialysis to remove nizatidine from the body has not been conclusively demonstrated; however, due to its large volume of distribution, nizatidine is not expected to be efficiently removed from the body by this method.

PV 2093 AMP [101591]

Additional information available to the profession on request

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OBITUARIES

Bernard P. Adelman, *Elkins Park*
Temple University School of Medicine, 1944; age 70, died November 9, 1991. Dr. Adelman was a radiologist.•

Toye G. Davis, *Oxford*
Howard University College of Medicine, 1947; age 81, died October 13, 1991. Dr. Davis was a general practitioner.•

Stewart F. Kretz, *Valencia*
Loyola University of Chicago Stritch School of Medicine, 1937; age 83, died October 26, 1991. Dr. Kretz was a general practitioner.•

August J. Podboy, *York*
Jefferson Medical College, 1932; age 85, died October 19, 1991. Dr. Podboy was an ophthalmologist.•

Edson R. Rodgers, *Darlington*
University of Pittsburgh School of Medicine, 1942; age 74, died October 23, 1991. Dr. Rodgers was an obstetrician and gynecologist.•

Dolores E. Rodriguez, *Danville*
Medical College of Pennsylvania, 1971; age 46, died October 15, 1991. Dr. Rodriguez was a pediatric neurologist.•

Victor L. Stotka, *Pittsburgh*
University of Pittsburgh School of Medicine, 1955; age 62, died November 9, 1991. Dr. Stotka was an internist.•

Howard E. Sullivan, *Bryn Mawr*
Jefferson Medical School, 1954; age 64, died October 10, 1991. Dr. Sullivan was an allergist.•

George L. Bowen, *Blue Bell*
George Washington University School of Medicine and Health Sciences, 1925; age 94, died October 17, 1991. Dr. Bowen was an obstetrician and gynecologist.

John J. Grant, *Pittsburgh*
University of Pittsburgh School of Medicine, 1943; age 73, died October 3, 1991. Dr. Grant was a general surgeon.

Joseph C. Grasberger, *West Chester*
Hahnemann University School of Medicine, 1937; age 79, died September 28, 1991. Dr. Grasberger was a psychiatrist.

Alvin Singer, *Roslyn*
Jefferson Medical College, 1955; age 66, died October 18, 1991. Dr. Singer was an internist.

Allen M. Snyder, *Thorndale*
Jefferson Medical College, 1949; age 67, died October 3, 1991. Dr. Snyder specialized in emergency medicine.

Robert R. Stoner Jr., *Camp Hill*
University of Pennsylvania School of Medicine, 1929; age 89, died October 12, 1991. Dr. Stoner was a general surgeon.

• Denotes membership in the Pennsylvania Medical Society at time of death.

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STATE SOCIETY OFFERS SERIES OF MEDICARE REFORM PROGRAMS

The implementation of the new Medicare payment reform regulations has triggered questions from physicians across the nation and in the Commonwealth. In response, the State Society has developed a series of educational programs.

To kick off the series, leaders of the State Society, county and specialty societies, and hospital medical staffs convened in Harrisburg on December 5, 1991, to be briefed on key elements of the final payment reform regulations. State Society staff discussed regulatory, legislative, and technical aspects of the reform and the resource based relative value scale (RBRVS) system, upon which it is based.

Representatives of Pennsylvania Blue Shield updated the leadership on the new evaluation and management (E/M or visit) codes (see Medical Economics on page 16) and other coding/payment policy changes. An extensive question-and-answer session followed. Based on positive feedback from the leadership meeting, regional meetings scheduled throughout January for all Pennsylvania physicians will feature and/or expand on many of the above issues.

Also as part of the series of educational programs, the Society is offering seminars for physicians' office personnel. The following is a tentative list of Winter/Spring 1992 programs, dates, and locations:

How to Master the New CPT Codes
January 28—Pittsburgh
January 29—Harrisburg
January 30—King of Prussia
February 4—Lehigh Valley
February 5—Erie
February 6—State College

How to Improve Your CPT and ICD-9 Coding Skills
March 17—Pittsburgh
March 18—Allentown
March 19—King of Prussia

How to Appeal Denied Claims
March 18—Pittsburgh
March 19—Allentown
March 20—King of Prussia

Medical Office Management Institute
April 21-24—Pittsburgh
April 28-May 1—King of Prussia

How to Run a More Profitable Place
May 5—Pittsburgh
May 6—Harrisburg
May 7—King of Prussia

Fee Analysis/Claims Analysis
May 12—Pittsburgh
May 13—Erie
May 14—Scranton
May 19—Harrisburg
May 20—Allentown
May 21—King of Prussia

Registration fees are discounted for office personnel employed by Pennsylvania Medical Society members. For specific information or to register by credit card, call the State Society's Department of Physician Services at 1-800-228-7823 or (717) 558-7750.

AMA PRIORITIZES 1992 ACTIVITIES

The American Medical Association (AMA) Board of Trustees has released its *1992 Plan and Budget*, which outlines the objectives and strategies the AMA will pursue during the next three years.

The six major issues in the plan include three strategic health policy issues and three strategic support issues:

- *Strategic health policy issues:* patient/physician advocacy, professionalism, and health of the public; and
- *Strategic support issues:* communications, membership, and federation unity.

Both areas cover a variety of more specific issues related to payment, liability, review, reform, and standards.

PHILADELPHIA SOCIETY HONORS PHYSICIANS

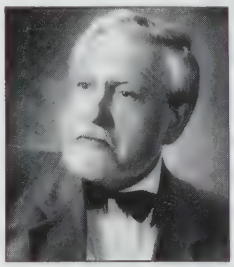
The Philadelphia County Medical Society (PCMS) honored outstanding members of Philadelphia's medical community during its annual "Awards Night" in November 1991.



Dr. Weiss

The highest honor of the evening, the Strittmatter Medal, was presented to William Weiss, MD, for his devotion, influence, and outstanding contribution to Philadelphia medicine. Dr. Weiss served as director of the Division of Occupational Medicine at Hahnemann before retiring as emeritus professor of medicine. He is respected for his writing and editing contributions to medicine, which include serving as a member of the editorial board for *Archives of Environmental Health* for almost two decades and as an editor of *Philadelphia Medicine*.

The Cristol Award for contributions to the county society's educational, scientific, and charitable goals was presented to Philip E. Ingaglio, MD, an attending physician at Saint Agnes Medical Center and chair of its Department of Family Medicine. Dr. Ingaglio has been an active and visible member of organized medicine on the county, state, and national levels since 1956.



Dr. Ingaglio

Several other physicians and community members were also honored:

- Vincent J. Zarro, MD, director of the Division of Clinical Pharmacology at Hahnemann, received the C. Nelson Davis Award for excellence in research and service devoted to educating physicians regarding addictive disorders afflicting physicians.
- Alma Dea Morani, MD, emerita professor of surgery at the Medical College of Pennsylvania, received the Krasnoff Award for the Practitioner of the Year for dedication in the area of patient care and community service.
- The Childbirth Education Association of Greater Philadelphia, which helps families be more active, informed, and aware during their childbearing years and beyond, received a Benjamin Rush Award for outstanding voluntary contributions to the health and welfare of the people of Philadelphia County.
- Max Silverstein, DSW, ACSW, emeritus professor of social work at the University of Pennsylvania, also received a Benjamin Rush Award for his volunteer contribution to programs and problems of the seriously chronically mentally ill.
- Marcia Meckler, MD, a practicing psychiatrist in several

national locum tenens positions, received the Kenneth Appel Award presented to the author who submits the best paper on clinical psychiatry relating to an experience in therapy or in research. Dr. Meckler was honored for her paper, "Eminent Care," which tells the story of early modern psychiatry, as seen through the illness and treatment of one man at one institution.

• William Roy Smythe, MD, a third-year surgical resident and assistant instructor in surgery at the University of Pennsylvania, received the Humaneness in Medicine Award for his technical surgical abilities and his compassion for patients.

• Twenty-seven Philadelphia physicians were honored with recognition awards for 50 years of medical service to the community.

ORTHOPEDIC SOCIETY ELECTS NEW PRESIDENT

The Pennsylvania Orthopedic Society elected Thomas H. Malin, MD, Camp Hill, as president for 1992. He will serve a one-year term.



Dr. Malin

Also elected to positions of the Orthopedic Society are: Arnold T. Berman, MD, Philadelphia, first vice president; Harry E. Rubash, MD, Pittsburgh, second vice president; Patrick B. Respet, MD, Allentown, secretary; and E. Michael Okin, MD, Philadelphia, treasurer.

AMA INTRODUCES NEW CONSUMER MAGAZINE

The American Medical Association (AMA) announced its collaboration with *Good Housekeeping* to produce the prototype of a new magazine called *Living Well*. Devoted to health topics, the new magazine will preview as a section in the March 1992 issue of *Good Housekeeping*, and then will appear as a stand-alone magazine on the newsstands in mid-March.

Living Well will provide readers with medical news in a "friendly, family doctor format," according to an AMA news release. It will feature interactive advice columns, essays by medical specialists, case histories, and in-depth features from leading science and health writers.

HARVARD, PENN STATE ANNOUNCE PROGRAM

A new professional development program, designed for leaders in continuing professional education, will be launched at Harvard University, March 22-27, 1992.

Co-sponsored by Harvard and Penn State, the "Leadership Institute for Continuing Professional Education" is a five-day residential program with a dual focus. Presentations will address 1) ways to improve programs, services, and delivery; and 2) ways to impact positively on professionals' learning and performance.

Much of the curriculum will be based on the Harvard case method, and the development of new curriculum materials will be underwritten by the W.K. Kellogg Foundation. For additional information, call Patricia Teti at (617) 495-3572.

MCMS PART OF DRUG/ ALCOHOL EDUCATION

The Montgomery County Medical Society (MCMS) in the past year

Is Your Practice Ready for Major Medicare Payment Reform?

How will RBRVS Affect Your Practice's Income?

If you don't know or are not sure, now is the time to find out. *LEADER Physician Services, Inc.* can help you evaluate the impact that Medicare-based payment reform will have on your practice.

Medicare payment reform, called the **Resource-Based Relative Value System (RBRVS)** will result in a fundamental change in the way medical services are reimbursed. When will it go into effect? Officially, phase-in of RBRVS is scheduled to begin January 1, 1992. The impact on your practice will vary depending on the mix of services provided, your geographic locality, and pre-RBRVS allowances.

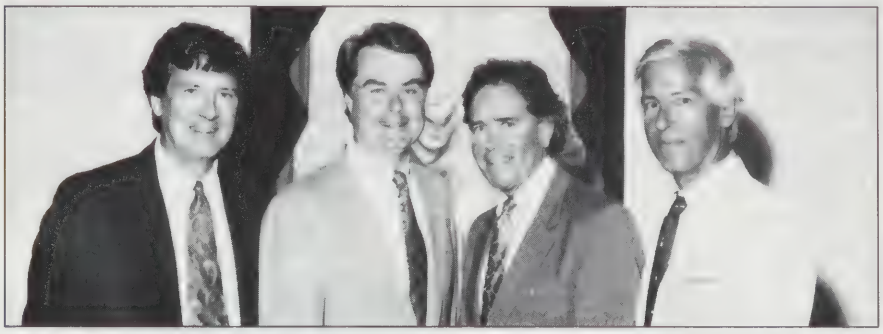
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The Montgomery County Medical Society (MCMS) invited county legislators to the first annual awards dinner of the County's Drug Awareness Coalition. Pictured (L-R) are: John E. Devenney, MD, MCMS president; The Honorable Joseph M. Gladeck Jr., 61st District representative; and William H. Mahood, MD, and Nicholas R. Rorick, MD, MCMS board members.

participated in several drug and alcohol education efforts.

As a member of the County's Drug Awareness Coalition—comprised of professionals and representatives of education, business, and labor—the county society rallied community, business, and labor groups to support and enhance successful programs already in place for youth to combat drug and alcohol abuse. Programs included: "Help Kids to Say No to Drugs," a full-day seminar for teachers, counselors, and parents; an awards dinner held to recognize three successful neighborhood drug/alcohol programs and distribute grants in support of the programs; a speakers bureau; fund-raising efforts; and an anti-drug public service advertising campaign.

ACMS SUPPORTS OUTREACH PROJECT

The Allegheny County Medical Society (ACMS) this fall lent its expertise to the *Breast Test*, a community outreach project funded by the Jewish Healthcare Foundation in Pittsburgh and produced by the National Outreach Center of QED Communications based in Oakland.

The *Breast Test*, a live television program on breast cancer, mammography, and self-examination, emphasized the need for early cancer detection. During the program, viewers were invited to call with questions. ACMS physicians, nurses, nurse practitioners, and health care management professionals answered the calls.

The one-hour program was interspliced with live interviews and video clips on breast exams, and although the program aired from 10:00-11:00 p.m., the telephones continued ringing until midnight. ACMS President Stanley M. Marks, MD, and his office manager, Karen Buzza, left the studio after midnight with more than 50 call-back requests in hand.

QED's National Media Outreach Center hopes to replicate the Pittsburgh-based pilot project with a national program for broadcast on the Public Broadcasting System (PBS).



Pittsburgh radio reporter Elaine Effort interviewed ACMS President Stanley M. Marks, MD, about breast cancer detection and treatment during the *Breast Test*, a pilot community outreach project.

AGS RELEASES REVISED *SYLLABUS*

The American Geriatrics Society (AGS) has released an expanded edition of *Geriatrics Review Syllabus: A Core Curriculum in Geriatric Medicine (GRS)*. AGS developed the program in clinical geriatrics to bring practicing physicians up-to-date on the practicalities of caring for older adults.

For more information or to request a review copy, call Patricia Miller at (212) 308-1414.

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Pennsylvania Medical Society

April 14-15

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142ND ANNUAL MEETING OF THE HOUSE OF DELEGATES

Opening Session
October 18, 1991

Jonathan E. Rhoads Jr., MD, Speaker of the House, called the opening session of the House of Delegates to order at 10:05 a.m. in the Exhibit Center of the Adam's Mark Hotel, Philadelphia.

Invocation

The Reverend Stanley Johnson, chaplain at the University of Pennsylvania, offered the invocation.

Pledge of Allegiance

Dr. Rhoads led the House of Delegates in the Pledge of Allegiance.

Credentials Committee

Charles D. Tourtellotte, MD, chairman, presented the following report:

Mr. Speaker, there is a quorum of 190 delegates registered and in attendance today.

Committee on Rules

Presented by:
James L. Cristol, MD

Mr. Speaker, members of the House of Delegates, the Committee on Rules met and reviewed Standing Rules 1, 2, 3, 4, 5, 6, 8, 9, and 10 of the House of Delegates of the Pennsylvania Medical Society as published in the 1991 Official Reports Book. (Standing Rule No. 7 will be addressed in the second report of the Rules Committee.)

Mr. Speaker, the Committee on Rules recommends that Standing Rules 1, 2, 3, 4, 5, 6, 8, 9, and 10 be adopted.

The House adopted Standing Rules 1, 2, 3, 4, 5, 6, 8, 9, and 10.

Approval of proceedings

The proceedings of the 141st Annual Business Meeting of the Pennsylvania Medical Society, held in Hershey October 19-21, 1991, and found on pages 55-79 in the January 1991 issue of PENNSYLVANIA MEDICINE, were approved.

Speaker's announcements

Dr. Rhoads announced that delegates should be aware of Resolution 72-6 prohibiting smoking in the House of Delegates and reference committee hearings.

Dr. Rhoads also announced that anyone encountering a medical emergency should dial 0 on the hotel phones and assistance would be provided.

Dr. Rhoads called to the attention of the House of Delegates the voting demonstration booth set up in the lobby to familiarize the delegates with the computer voting system instituted at the 1990 annual meeting.

Address of the president

Gordon K. MacLeod, MD, Allegheny County, addressed the House, during which he made the following recommendation:

1. Efforts be pursued to focus the decision-making process in the presidency, giving full consideration to upgrading the management of legislative and judicial activities of the Society (Reference Committee F).

Address of the President Elect

Robert N. Moyers, MD, Crawford County, addressed the House, during which he made the following recommendations:

1. The Society investigate the advisability of assisting local societies in establishing a patient grievance/mediation system, working with the American Medical Association and with the Federal Trade Commission to redefine that agency's guidelines (referred to Reference Committee F).

2a. Continue to pursue the Society's indigent care plan, working to implement portions of the plan as practical (referred to Reference Committee C).

2b. The Society continue activity supporting the AMA's Health Access America (referred to Reference Committee E).

2c. The Society strengthen efforts to reverse the "doctor drain" from rural and inner-city areas of the Commonwealth (referred to Reference Committee B).

2d. The Society develop a specific plan to be far more active in the public health arena, a four-step public health plan for the Society to follow for the next several years (referred to Reference Committee G).

3. The Society consider creating an innovative plan to strengthen professionalism (referred to Reference Committee F).

4a. Using the Council on Membership and HMSS Governing Council to establish specific goals and a recruiting plan to focus on non-members;

b. A peer-to-peer, "a member-to-member" plan;

c. Special membership programs at the county level;

d. A challenge to county societies to set specific recruitment goals for 1992. I suggest a two percent increase in principal dues-paying members is reasonable;

e. Special recruiting plans for women and minorities;

f. Incentive plans to sign up members, such as some form of gift, dues reduction, or special recognition; and

g. An innovative plan to reach other groups of non-members in medical school faculties, large group practices, managed care groups, etc. (all referred to Reference Committee F).

5. Establishment of a joint committee with the American Association of Retired Persons as agreed upon at a recent meeting of the AARP State Legislative Committee (referred to Reference Committee D).

6. Consideration of establishing an ongoing program to invite all Pennsylvania Congressional legislative assistants, whose responsibilities include health care, to group educational meetings at appropriate intervals (referred to Reference Committee D).

7a. Development of appropriate educational, informational, and reference capabilities to help members prepare for and deal with RBRVS and the Medicare fee schedule as well as coding changes;

b. Strengthen efforts to achieve use of HCFA form 1500 for all claims; and

c. Continue to pursue legislation mandating reasonable payment timeframes for issues such as coding changes (all referred to Reference Committee E).

d. Pursuing procedural safeguards in the PRO process (referred to Reference Committee C).

Remarks of AMA representative

John H. Hobart, MD, chairman of the Board of Trustees, introduced John J. Ring, MD, president of the American Medical Association, who briefly addressed the House.

Miscellaneous

It was moved and seconded from the floor of the House to adopt Resolution 91-8: Honoring the American Lung Association of Pennsylvania.

RESOLVED, That the Pennsylvania Medical Society applaud the American Lung Association of Pennsylvania on its 100th anniversary and recognize the accomplishments of the American Lung Association of Pennsylvania in its century of service to Pennsylvania.

The House adopted Resolution 91-8.

Official Reports Book

The *Official Reports Book*, containing the 1991 annual reports and Resolutions 91-1 through 91-47, was accepted as business of the House.

Please refer to the index of these proceedings for the subject, author, introducer, and referral of all resolutions.

Referral of business items

Howard A. Richter, MD, vice speaker of the House, announced that Board Report L had been re-referred from Reference Committee E to C.

Dr. Richter also announced that Resolution 91-12 was inadvertently collated in with Reference Committee B resolutions and should be placed with Reference Committee F resolutions; Resolutions 91-25, 91-29, and 91-38, Board Report S, and the attachment to Board Report AA had been revised; and Resolution 91-46 and late Resolution 91-48 had been withdrawn.

Additional business items

Dr. Richter announced that the

following additional reports had been received for consideration: Board Report II, Board Report AAA, and Board Report BBB.

Remarks by Finance Committee

John W. Lawrence, MD, chairman of the Finance Committee, presented brief remarks. A detailed report on the 1992 budget was presented by Dr. Lawrence at the hearing of Reference Committee F.

Presentation of memorial resolution

George F. Buerger Jr., MD, Allegheny County, presented a eulogy and the following memorial resolution for the late Walter M. Greissinger, MD:

WHEREAS, Walter M. Greissinger, MD, passed away suddenly and unexpectedly on June 14, 1991; and

WHEREAS, Dr. Greissinger served the profession of medicine long and well, compassionately caring for his patients and vigorously representing his colleagues in the public eye; and

WHEREAS, At the time of his death, he was serving as the trustee for the Tenth District; therefore be it

RESOLVED, That the Pennsylvania Medical Society extend its deepest sympathy to Dr. Greissinger's wife, Terri, and to his children, Paul, Karl, Michelle, Kimberly, and Lisa, and commend Dr. Greissinger's leadership and timeless work on behalf of his patients and profession.

The House of Delegates adopted the memorial resolution for Walter M. Greissinger, MD.

Remarks by chairman, Pennsylvania Delegation to the AMA

Joseph N. Demko, MD, chairman of the Pennsylvania Delegation to the AMA, briefly addressed the House.

Late Resolutions

Late Resolution 91-49 was received after the mailing of the *Official Reports Book* and required a two-thirds vote to become business of the House. Standing Rule 2, revised by the 1981 House of Delegates, requires that the Rules Committee review each late resolution and make a recommendation to the House as to whether it should be accepted or rejected as business of the House. Standing Rule 2, as revised by the 1987 House of Delegates, states that resolutions emanating from a business meeting of an officially recognized section of the Pennsylvania Medical Society may be presented for consideration by the House of Delegates at any time before the close of business at the opening session of the House and therefore does not require review by the Rules Committee. Resolutions 91-50 through 91-65 were submitted by special sections. In addition, Standing Rule 2, as revised by the 1990 House of Delegates, states that any resolution submitted after the Rules Committee has convened will require a three-fourths favorable vote to become business of the House.

Committee on Rules

Presented by:
James L. Harrison, MD

Mr. Speaker, the Committee on Rules has considered all of the items in the index.

RESOLUTION 91-7: Bullet Balloting

RESOLVED, That henceforth, "bulleting balloting" be eliminated by the House of Delegates of the Pennsylvania Medical Society for all elections.

Mr. Speaker, your Committee on Rules recommends that Resolution 91-7 be adopted and that Standing Rule 7 should read as follows:

The bullet ballot will, henceforth, be discontinued. It is required that if there are multiple candidates for positions of equal rank, a vote for every position must be cast. Failure to vote for all positions will invalidate the ballot.

Resolution 91-7 recommends that the bullet ballot be discontinued. The Rules



Access to health care was one of the many issues debated during hearings of the Reference Committee on Education and Science, chaired by Abram M. Hostetter, MD.

Committee heard considerable testimony on this issue. The issues surrounding the bullet ballot center on (1) requiring delegates to vote for more candidates than they wish to, and (2) compelling delegates to vote for candidates who are relatively unknown to them.

It is the opinion of the Rules Committee that candidates with good qualifications and vast experience have not been elected as a result of the bullet ballot. The committee believes this is not in the best interest of the Society and minimizes the influence of the Society at the AMA House of Delegates. These factors outweigh other concerns.

With regard to delegates' concerns about not knowing all candidates, the committee believes adequate information about nominees is available through printed materials and from the "Meet the Candidates Breakfast."

It was moved and seconded from the floor that the House vote on whether to retain the bullet ballot. The House approved the motion. The House rejected by two-thirds vote the recommendation that the bullet ballot be retained.

RESOLUTION 91-40: Bullet Ballot

RESOLVED, That the Pennsylvania Medical Society House of Delegates charge an ad hoc committee with the responsibility to study adoption of the following Standing Rule:

Standing Rule No. 11
Election rules for offices requiring election of multiple individuals

When a single election ballot contains multiple candidates who are competing to be among a group of people elected to a given position, the previous Standing Rules will be superseded by the following procedure: **The voter will be asked to RANK his/her choices**. When the votes are tabulated, the individual ranked highest on each ballot will receive a number of points equal to the total number of people who are to be elected to this position; the individual ranked next will receive one fewer point, the next will receive two fewer, and so forth either until the voter has ceased to record choices or until a full complement of individuals has been chosen. The individuals with the highest point-totals will be viewed as the winners of the election. In the case of a tie, the position will be awarded to the individual with the greater number of first-place votes or (were the number of first-place votes to have been a tie) to the individual with the greater number of second-place votes, and so forth.

Mr. Speaker, your Committee on Rules recommends that Resolution 91-40 be adopted.

This resolution calls for a study of a voting system which would allow delegates to rank selected candidates. The committee recommends that this resolution be used as a vehicle to study the entire election process including approval voting which is used by many scientific organizations.

The House adopted Resolution 91-40.

RESOLUTION 91-49: Pennsylvania Medical Society Position on Biomedical Research and Testing

Mr. Speaker, your reference committee recommends that Resolution 91-49 be accepted as business of the House.

The House accepted as business Resolution 91-49.

Speaker's announcements

Dr. Richter called to the attention of the House of Delegates the State Society ties and golf shirts available for purchase from The Educational and Scientific Trust at the display in the Exhibit Center Lobby.

Address of Pennsylvania Medical Society Auxiliary president

Dr. Richter introduced Mrs. John Modarress, president of the State Society Auxiliary. Mrs. Modarress briefly addressed the House, and her remarks were referred to Reference Committee F.

Dr. Rhoads introduced Mrs. Gary F.

Strebel, AMA auxiliary president, who also briefly addressed the House.

Reference Committees

Reference committees for the 1991 Annual Business Meeting of the House of Delegates are listed below:

Reference Committee A (Bylaws): James L. Cristol, MD (Philadelphia), chairman; Mary B. Allan, MD (Chester); Ronald J. Clearfield, MD (Radiology); Lewis T. Patterson, MD (Dauphin); Frank J. Santora Jr., MD (Allegheny); and Jeffrey D. Anderson, MD (Resident Physician Section), alternate.

Reference Committee B (Education and Science): Abram M. Hostetter, MD (Lebanon), chairman; Doris G. Bartuska, MD (Philadelphia); Richard T. Bell, MD (Pulmonary Diseases); Mary J. Kinosian, MD (Jefferson); Phillip R. Levine, MD (Allegheny); and Mark S. Friedlander, MD (Resident Physician Section), alternate.

Reference Committee C (Facilities/Peer Review): Alan H. Schragger, MD (Lehigh), chairman; Robert P. Gannon, MD (Allegheny); Stanley P. Mayers Jr., MD (Centre); Gladys M. Miller, MD (Philadelphia); and Mandell J. Much, DO (Delaware).

Reference Committee D (Legislation/Professional Liability): Carol E. Rose, MD (Allegheny), chairman; Andre C. Blanzaco, MD (Philadelphia); David L. Cohen, MD (York); S. Victor King, MD (Blair); Gary J. Levin, MD (Chester); and Daniel S. Henriksen, MD (Resident Physician Section), alternate.

Reference Committee E (Medical Economics): Donald H. Smith, MD (Northampton), chairman; Wilma C. Light, MD (Westmoreland); Leland F. Patterson, MD (Dauphin); Robert B. Sklaroff, MD (Philadelphia); Richard R. Soricelli, MD (Delaware); and Thomas F. Freenock Jr., MD (Resident Physician Section), alternate.

Reference Committee F (Membership/Reports of Officers): Edward J. Resnick, MD (Philadelphia), chairman; Augusto N. Delerme, MD (Blair); John Helwig Jr., MD (Philadelphia); Edward V. Twiggar II, MD (Northumberland); Anne N. Woods, MD (York); and Surendra V. Pawar, MD (Allegheny), alternate.

Reference Committee G (Public Health): Howard L. Carbaugh, MD (Lehigh), chairman; Elias Abrutyn, MD (Philadelphia); Carl A. Frankel, MD (Young Physicians Section); J. Campbell Martin, MD (Columbia); Barbara A. Shelton, MD (Philadelphia); and Ernest M. Wood, MD (Lancaster).

Rules: James L. Harrison, MD (Lycoming), chairman; Richard D. Baltz, MD (Dauphin); Robert J. Carroll, MD (Allegheny); Wallace G. McCune, MD (Philadelphia); and James A. Morris Jr., MD (Delaware).

Credentials: Charles D. Tourtellotte, MD (Rheumatology), chairman; Richard P. Albertson, MD (Montgomery); Norman L. Ekberg, MD (Montour); Nancy S. Nieland, MD (Allegheny); Thomas J. Weida, MD (Lancaster); and Edward M. Zimmerman, MD (Beaver).

Tellers: Samuel G. Woodings, MD (Mercer), chief teller; George H. Benz Jr., MD (Allegheny); Gertrude L. Blumenschein, MD (Fayette); Winston M. Bryant Jr., MD (Philadelphia); Louise Jacobson, MD (Lackawanna); David L. Katz, MD (Allegheny); Michael J. Prendergast, MD (York); and Roberta L. Schneider, MD (Montgomery).

Second Session
October 19, 1991

The second session of the House of Delegates was called to order at 1:06 p.m. in the Exhibit Center of the Adam's Mark Hotel, Philadelphia.

Credentials Committee

Charles D. Tourtellotte, MD, chairman, presented the following report:

Mr. Speaker, there is a quorum of 266 delegates registered and in attendance today.

Dr. Rhoads reported that there was no representation in the House of Delegates from Armstrong, Butler, Carbon, Greene, McKean, Mifflin-Juniata, Perry, Potter, Susquehanna, Warren, Washington, and Wyoming Counties, and the specialties of gastroenterology, neurological surgery, plastic surgery, and otolaryngology.

Reference Committee A

Presented by:
James L. Cristol, MD

Mr. Speaker, members of the House of Delegates, Reference Committee A has considered all of the items in the index.

REPORT A, COMMITTEE ON BYLAWS, SUBJECT 1: Revision to Pennsylvania Medical Society Young Physicians Section County Representation Methodology

Mr. Speaker, your reference committee recommends that the Bylaws change appearing in the Official Call under Subject 1 be adopted.

This Bylaws revision would entitle each county medical society to one voting representative to the Young Physicians Section for every 200 or fraction thereof young physicians in that county.

The Committee heard no negative comment on this Bylaws provision.

The House adopted the Bylaws change as presented in Subject One of the Official Call.

REPORT A, COMMITTEE ON BYLAWS, SUBJECT 2: County Medical Societies Increasing but not Decreasing Their Delegate Count to the Pennsylvania Medical Society House of Delegates for a Period of Two Years Due to Unification with the AMA

Mr. Speaker, your reference committee recommends that the Bylaws changes appearing in the Official Call under Subject 2 be adopted.

The committee heard no negative comments on these Bylaws provisions.

The House adopted the Bylaws changes as presented in Subject Two of the Official Call.

REPORT A, AD HOC COMMITTEE ON BOARD RESTRUCTURING

Mr. Speaker, your reference committee recommends that the report of the Ad Hoc Committee on Board Restructuring be adopted.

The Ad Hoc Committee on Board Restructuring recommends Bylaws changes which would result in the creation of a 13th District (Allegheny County) and a restructured 10th District composed of Lawrence, Beaver, and Westmoreland Counties. These changes would also result in the allocation of two trustees to those districts having over 3,000 members.

Your reference committee heard strong testimony both for and against consideration of the final recommendation of this report. The predominance of discussion was directed at the question of whether the Bylaws changes involved in the report should be considered separately. The majority of the testimony favored adoption of the report in total.

It was moved and seconded from the floor of the House to refer back to the Board of Trustees Report A of the Ad Hoc Committee on Board Restructuring. The House rejected the motion to refer by a vote of 125 to 120.

It was moved and seconded from the floor of the House to divide the issue, voting separately on the recommendation of the Ad Hoc Committee on Board Restructuring that a new District Thirteen be created consisting of Allegheny County, and that two trustees be allocated to districts having over 3,000 members. The House approved the motion to divide the issue.

It was moved and seconded from the floor of the House to amend the recommendation of the Ad Hoc Committee on Board Restructuring to state that Allegheny County remain the Tenth District, Lawrence and Beaver Counties be incorporated into the Ninth District, and Westmoreland County be incorporated into the Eleventh District.

It was moved and seconded from the floor of the House to reconsider referral back to the Board of Trustees Report A of the Ad Hoc Committee on Board Restructuring. The House approved the motion to reconsider referral. The House approved referring Report A by a vote of 148 to 114.

REPORT A, COMMITTEE ON BYLAWS, SUBJECT 4: Waiving the Annual Dues Assessment in the Year after Maternity Leave

Mr. Speaker, your reference committee recommends that the Bylaws change appearing in the Official Call under Subject

4 be adopted.

The reference committee heard no negative comment on these Bylaws provisions.

The House adopted the Bylaws change as presented in Subject Four of the Official Call.

Reference Committee F

Presented by:
Edward J. Resnick, MD

Mr. Speaker, members of the House of Delegates, Reference Committee F has considered all of the items in the index. In addition, your reference committee received a presentation from the chairman of the Finance Committee, John W. Lawrence, MD. Final review and consideration of that report will be the last item of business for this House of Delegates; therefore, it is not included in Reference Committee F's report.

REPORT C, BOARD OF TRUSTEES: RESOLUTION 89-9, Ten-Year Sunset Provision for Pennsylvania Medical Society Policy; RESOLUTION 89-10, Digest of Pennsylvania Medical Society Policy Actions; and RESOLUTION 89-22, Access to Established Policies of Organized Medicine

Mr. Speaker, your reference committee recommends that the actions indicated for each policy in the policy chart referenced in Report C, Board of Trustees be adopted.

It was moved and seconded from the floor of the House to extract Resolution 81-30, Private Sector Medical Economics Administration of Medicaid, from the policy list attached to Board Report C. The House approved the motion. It was moved and seconded that Resolution 81-30 be retained rather than rescinded. The House approved retaining Resolution 81-30. The House adopted the action indicated for all other policies in the policy chart referenced in Board Report C.

Mr. Speaker, your reference committee recommends that the remainder of Report C, Board of Trustees be filed.

The House approved filing the remainder of Board Report C.

REPORT I, BOARD OF TRUSTEES: Recommendation 8 of 1990 President Elect Dealing with a Second Meeting of House of Delegates

Mr. Speaker, your reference committee recommends that the recommendation for a second meeting of the House of Delegates not be adopted.

The issue of a second meeting of the House of Delegates did not generate any discussion and, therefore, your reference committee agrees with the preponderance of information in Report I of the Board of Trustees against a second meeting.

The House did not adopt Recommendation 8.

Mr. Speaker, your reference committee recommends that Report I, Board of Trustees be filed.

The House approved filing Board Report I.

REPORT MM, BOARD OF TRUSTEES: Allocation to Support Student Loan Program

REPORT VV, BOARD OF TRUSTEES: RESOLUTION 90-84, Augmenting Student Loan Program

REPORT A, COMMITTEE ON AID TO EDUCATION: Annual Report of the Activities of the Committee on Aid to Education

Mr. Speaker, your reference committee recommends that Report MM of the Board of Trustees be adopted in lieu of Report VV of the Board of Trustees and Report A of the Committee on Aid to Education.

Report MM, Board of Trustees deals with the allocation of $10 from the 1992 annual assessment of members to support the Student Loan Program. Report VV, Board of Trustees requests that the annual assessment be increased to cover any additional allocation of funds to support student loans. Report A, Committee on Aid to Education requested an increase in the allocation of dues by $2 a year for the next five years beginning with the 1992 dues received from all active members, bringing the total allocation to $20 by 1996. Your reference committee encourages members of the Pennsylvania Medical Society to continue their generous voluntary contributions to The Educational and Scientific Trust.

The House adopted Board Report MM.

REPORT A, SPECIAL COMMITTEE ON AMA DELEGATION MATTERS: REPORT HH, Board of Trustees; RESOLUTION 90-32, Funding of the Pennsylvania Medical Society-AMA Delegation; RESOLUTION 90-40, Funding of the Pennsylvania Medical Society-AMA Delegation; RESOLUTION 90-41, Full Slate of Alternate Delegates; RESOLUTION 90-51, Pennsylvania Medical Society Delegation to the AMA Expenses; RESOLUTION 90-5, Nomination of Delegates and Alternate Delegates to the AMA; and RESOLUTION 90-9, Accountability of the Pennsylvania Delegation and Alternate Delegates to the AMA

REPORT OO, BOARD OF TRUSTEES: Board of Trustees; 1990 REPORT HH; RESOLUTION 90-41, Full Slate of Alternate Delegates; RESOLUTION 90-51, Pennsylvania Medical Society Delegation to the AMA Expenses; and RESOLUTION 90-9, Accountability of the Pennsylvania Delegation and Alternate Delegates to the American Medical Association

Mr. Speaker, your reference committee recommends that Report A, Special Committee on AMA Delegation Matters be adopted.

The general tone of the testimony convinced the committee of the appropriateness of Report A, Special Committee on AMA Delegation Matters.

It was moved and seconded from the floor of the House to refer Report A to the Board. The House did not approve the motion. The House adopted Report A.

Mr. Speaker, your reference committee recommends that Report OO, Board of Trustees be filed.

The House approved filing Board Report OO.

REPORT A, SPECIAL COMMITTEE TO STUDY COMBINING THE OFFICE OF PRESIDENT AND CHAIRMAN

Mr. Speaker, your reference committee recommends that Report A, Special Committee to Study Combining the Office of President and Chairman, be adopted.

This report has to do with combining the office of president and chairman. Your reference committee heard compelling arguments on both sides of the issue. The committee was favorably impressed by the argument for continuity of service by the chairman of the Board and the concept that the president of the Society be the spokesman and public leader of the Society.

It was moved and seconded from the floor of the House to refer Report A back for further study and development of a specific plan. The House did not approve the motion. The House adopted Report A.

RESOLUTION 91-12: Membership Requirements

RESOLVED, That AMA membership no longer be required as a condition for membership in the Pennsylvania Medical Society.

Mr. Speaker, your reference committee recommends that Resolution 91-12 not be adopted.

This resolution recommended deunification with the AMA. The response in the reference committee hearing was strongly against this resolution.

The House did not adopt Resolution 91-12.

RESOLUTION 91-34: Dues Freeze and Prioritization of Society Activities

RESOLVED, That there be no increase in dues this fiscal year; and be it further

RESOLVED, That the Pennsylvania Medical Society House of Delegates mandate the Pennsylvania Medical Society Board of Trustees to prioritize all activities of the Society and to fund only the activities which can be afforded within the dues income; and be it further

RESOLVED, That the Pennsylvania Medical Society Board of Trustees keep the Pennsylvania Medical Society House of Delegates informed of their decisions.

Mr. Speaker, your reference committee recommends that Resolution 91-34 not be adopted.

This resolution dealt with requiring the Society not to increase the dues and to prioritize all Society activities to accomplish that goal. Your reference committee feels that the intent of this resolution has already been accomplished.

The House did not adopt Resolution 91-34 by a vote of 128 to 110.

RESOLUTION 91-35: Effective Mechanism for Installment Payment of Dues

RESOLVED, That the Board of Trustees be directed to implement a quarterly dues payment plan of four equal amounts.

Mr. Speaker, your reference committee recommends that Resolution 91-35 be amended as follows:

RESOLVED, That the Board of Trustees be directed to [implement] study a quarterly dues payment plan of four equal amounts.

Mr. Speaker, your reference committee recommends that Resolution 91-35 be adopted as amended.

This resolution dealt with providing a quarterly dues billing program for members of the Pennsylvania Medical Society. The committee recognizes the complexity of such a plan and feels further study is warranted. Some of the issues that need to be considered include Bylaws changes and administrative problems in managing such a plan. Fiscal impact would also have to be considered.

The House did not adopt the amendment. It was moved and seconded from the floor of the House to amend Resolution 91-35 by replacing the word, implement, with the word, continue, and replacing the words, "four equal amounts." with the words, "with appropriate notification of such a plan on dues notices." The House adopted the amendment. The House adopted Resolution 91-35 as amended.

RESOLUTION 91-55: Conflict of Interest

RESOLVED, That the Pennsylvania Medical Society adopt the following policy and recommend that the AMA do likewise:

Physicians who intend to provide input regarding the formulation of policy within any organ of organized medicine who may have a conflict of interest are encouraged to provide such input, preceded by the provision of a disclaimer (oral or written) regarding the potential for said conflict of interest to affect the recommend policy position.

Mr. Speaker, your reference committee recommends that Resolution 91-55 not be adopted.

The Judicial Council, as reported in Report A of the Judicial Council, is already addressing the issue of conflict of interest. Therefore the committee felt that the resolution is redundant.

The House did not adopt Resolution 91-55.

RESOLUTION 91-59: Number of Pennsylvania Medical Society-Young Physicians Section Delegates to the Pennsylvania Medical Society House of Delegates

RESOLVED, That the Pennsylvania Medical Society alter its Bylaws in order to grant the Pennsylvania Medical Society-Young Physicians Section the same number of delegates and alternate delegates to the Pennsylvania Medical Society House of Delegates as are eligible to be sent to the AMA-YPS Annual Assembly.

Mr. Speaker, your reference committee recommends that Resolution 91-59 not be adopted.

This resolution dealt with increasing the number of YPS delegates in the State Society House of Delegates. Your reference committee felt that it is not necessary to conform to the rules of the AMA Young Physicians Assembly in determining the number of delegates from the YPS to this House.

It was moved and seconded from the floor of the House to refer to the Board of Trustees for study Resolution 91-59. The House approved referring Resolution 91-59 by a vote of 180 to 107.

Waiver of debate list

The following items have been grouped together in a waiver of debate list; little or no testimony was heard, and the committee feels that the items are of a noncontroversial nature.

Mr. Speaker, your reference committee recommends adoption:

REPORT NN, BOARD OF TRUSTEES: Annual Assessment for Students

REPORT B, BOARD OF TRUSTEES: RESOLUTION 90-81, Slotted Alternate Delegate Position on the Pennsylvania AMA Delegation

REPORT D, BOARD OF TRUSTEES: RESOLUTION 90-22, Encouraging Osteopathic Physicians who Are Members of the American Osteopathic Association and Pennsylvania Osteopathic Medical Association to Join Allopathic County Medical Societies by Exemption from Unified Membership Requirements; and RESOLUTION 90-27, Encouraging Encouraging Osteopathic Physicians who Are Members of the Pennsylvania Osteopathic Association and the American Osteopathic Medical Association to Join Allopathic Medical Societies by Exemption from Unified Membership Requirements.

REPORT G, BOARD OF TRUSTEES: RESOLUTION 90-70, Resolving Grievances

REPORT GG, BOARD OF TRUSTEES: Recommendation 1 of the President Elect, Regional Medical Societies

REPORT HH, BOARD OF TRUSTEES: Recommendation 1 of the President, Public Health Initiatives for County Societies

REPORT WW, BOARD OF TRUSTEES: RESOLUTION 90-54, Unified Membership

REPORT XX, BOARD OF TRUSTEES: RESOLUTION 90-16, Pennsylvania Medical Society Staff Contribution to the Process of Formulation of Society Policies

It was moved and seconded from the floor of the House to extract Board Report D from the waiver of debate list. The House approved the motion. It was moved and seconded from the floor of the House to amend Board Report D by deleting lines 33 through 35 in the report which state, "Numerically, this is less than the losses experienced in many specialties. Percentage-wise, the net loss of DO members is not much different than family physicians." The House adopted the amendment. The House adopted as amended Board Report D.

The House adopted the remainder of the waiver of debate items.

Mr. Speaker, your reference committee recommends not for adoption:

RESOLUTION 91-10: Dues Exemption for Fully Retired Physicians

RESOLVED, That the Pennsylvania Medical Society grant dues-exempt status to members who are fully retired and who are least 65 years of age.

RESOLUTION 91-36: Timely Consideration of Actions Effecting Pennsylvania Medical Society Dues

RESOLVED, That all actions which, if approved by the House of Delegates, will cause Pennsylvania Medical Society dues to be other than that announced at the opening of the House must be considered by the House of Delegates by close of business on the next to last day of the annual meeting, currently Saturday.

RESOLUTION 91-56: Recognition of "Specialty" Boarded Status

RESOLVED, That the Pennsylvania Medical Society consider the pursuit of the following policy:

No professional society shall require the payment of an annual fee in order to maintain specialty boarded status.

RESOLUTION 91-60: Fiscal Note

RESOLVED, That the Pennsylvania Medical Society adopt the following policy and recommend its adoption by the AMA:

All resolutions must be submitted with a fiscal note prepared by the author. Critique thereof will be provided by staff at the time adoption of said policy is to be considered (employing a reference committee when such a mechanism is available); if possible, the author will be apprised of the critique ahead of time.

It was moved and seconded from the floor of the House to extract Resolution 91-56. The House approved the motion. It was moved and seconded from the floor of the House to refer for study Resolution 91-56. The House did not approve the motion to refer. The House did not adopt Resolution 91-56.

The House did not adopt the remainder of

the waiver of debate items.

Mr. Speaker, your reference committee recommends for referral to the Board of Trustees for report back to the House of Delegates:

RESOLUTION 91-65: National Scholarship Fund

RESOLVED, That the Pennsylvania Medical Society, Pennsylvania Medical Society Auxiliary, and Pennsylvania Medical Society Medical School Section investigate mechanisms by which a universal scholarship fund may be made available to medical students in the Commonwealth of Pennsylvania; and be it further

RESOLVED, That the State Society AMA Delegation be directed to draft a similar resolution for a national scholarship fund; and be it further

RESOLVED, That these scholarships be made available to medical students who agree to serve, or demonstrate a background of prior service to, the indigent population of the United States; and be it further

RESOLVED, That these scholarships be named in the memory of Walter Greissinger, MD, whose support of medical students and medical professionals in Pennsylvania was without compare.

RESOLUTION 91-26: Honoring a Pennsylvania Medical Society Physician Member for Community Volunteer Service

RESOLVED, That the Pennsylvania Medical Society honor on a yearly basis an outstanding Society member who has distinguished himself or herself in volunteer community service; the Awards Committee shall develop criteria and solicit nominations from the county societies for this award.

ADDRESS OF THE PRESIDENT, GORDON K. MACLEOD, MD: RECOMMENDATION

ADDRESS OF THE PRESIDENT ELECT, ROBERT N. MOYERS, MD: RECOMMENDATION 1

ADDRESS OF THE PRESIDENT ELECT, ROBERT N. MOYERS, MD: RECOMMENDATION 3

ADDRESS OF THE PRESIDENT ELECT, ROBERT N. MOYERS, MD: RECOMMENDATION 4

The House approved referring the waiver of debate items to the Board of Trustees for report back to the House of Delegates.

Mr. Speaker, your reference committee recommends filing:

REPORT A, BOARD OF TRUSTEES

REPORT KK, BOARD OF TRUSTEES

NECROLOGY REPORT, BOARD OF TRUSTEES

REPORT A, COUNCIL ON MEMBERSHIP

REPORT A, JUDICIAL COUNCIL

REPORT A, THE EDUCATIONAL AND SCIENTIFIC TRUST

REPORT A, COMMITTEE ON MEDICAL BENEVOLENCE

REPORT A, ADVISORY COMMITTEE ON PROFESSIONALISM

REPORT A, SECRETARY

REPORT A, TREASURER

REPORT A, AUDITOR

REPORT A, RESIDENT PHYSICIAN SECTION

REPORT A, YOUNG PHYSICIANS SECTION

REPORT A, MEDICAL STUDENT SECTION

REPORT A, EXECUTIVE VICE PRESIDENT

REPORT A, PENNSYLVANIA DELEGATION TO THE AMA

TRUSTEE REPORTS: First through Twelfth Districts, Specialty, Hospital Medical Staff, Young Physician, Resident Physician, and Medical Student

ADDRESS OF THE PENNSYLVANIA MEDICAL SOCIETY AUXILIARY

PRESIDENT, MRS. JOHN MODARRESS

ADDRESS OF THE PRESIDENT, GORDON K. MACLEOD, MD

ADDRESS OF THE PRESIDENT ELECT, ROBERT N. MOYERS, MD

The House approved filing the waiver of debate items.

Reference Committee C

Presented by:
Alan H. Schragger, MD

Mr. Speaker, members of the House of Delegates, Reference Committee C has considered all of the items in the index.

RESOLUTION 91-39: Small Area Analysis

RESOLVED, That the Pennsylvania Medical Society adopt the policy position regarding the technology of Small Area Analysis that it remains of unproven utility; and be it further

RESOLVED, That the Pennsylvania Medical Society ask the AMA to study Small Area Analysis and consider co-adoption of the aforementioned State Society policy *in the absence of data which document its utility.*

Mr. Speaker, your reference committee recommends that the first resolved of Resolution 91-39 be deleted and the second resolved be amended as follows:

RESOLVED, That the Pennsylvania Medical Society ask the AMA to continue its study of Small Area Analysis.

Mr. Speaker, your reference committee recommends that Resolution 91-39 be adopted as amended.

Resolution 91-39 calls on the Pennsylvania Medical Society to adopt the policy position regarding the technology of Small Area Analysis that it remains of unproven utility; and further, calls on the Pennsylvania Medical Society to ask the AMA to study Small Area Analysis and consider co-adoption of the



Thomas H. Malin, MD, (C-seated) and other delegates of the Society's specialty section review materials handed out during the 1991 annual meeting of the House.

aforementioned Pennsylvania Medical Society policy *in the absence of data which document its utility.*

Your reference committee heard considerable testimony in support and opposition to this resolution. The committee does feel, however, that continued study of Small Area Analysis as an epidemiological tool has value and should be encouraged.

The House adopted as amended Resolution 91-39.

RESOLUTION 91-43: Publication in *Federal Register* of Proposed Changes in Pro Review Process or Procedures

RESOLVED, That the Pennsylvania Medical Society work cooperatively with the AMA to urge HCFA to publish in the *Federal Register* any proposed changes in the PRO review process or procedures which would impact on physician practice patterns and/or the delivery of medical care, including the proposed practice guidelines when they are developed.

Mr. Speaker, your reference committee recommends that Resolution 91-43 be adopted.

Resolution 91-43 calls on the Pennsylvania Medical Society to work cooperatively with the AMA to urge HCFA to publish in the *Federal Register* any proposed changes in the PRO review process or procedures which would impact on physician practice patterns and/or the delivery of medical care, including the proposed practice guidelines when they are developed.

Your reference committee heard testimony in support of this resolution. It was also noted that KePRO supports this resolution as well.

It was moved and seconded from the floor of the House to refer Resolution 91-43. The House did not approve the motion. The House adopted Resolution 91-43.

RESOLUTION 91-52: Proper Notification of a Physician Regarding Possible Loss of Medical Staff Membership or Privileges

RESOLVED, That the Pennsylvania Medical Society adopt the policy that hospital notification of possible loss of medical staff membership must be sent by certified mail, return receipt requested; and be it further

RESOLVED, That the Pennsylvania Medical Society adopt the policy that an appropriate appeals process (such as that which is written in the Pennsylvania Medical Society Model Medical Staff Bylaws) for possible loss of medical staff membership for *any* reason must be part of the medical staff Bylaws; and be it further

RESOLVED, That the aforementioned procedure must be included in the Pennsylvania Medical Society Model Medical Staff Bylaws; and be it further

RESOLVED, That the existence of the aforementioned procedure must be communicated to all Pennsylvania hospital medical staffs.

RESOLUTION 91-53: Appropriate Appeals Procedure Following Recommendation by the Medical Executive Committee Regarding Loss of Medical Staff Membership or Privileges

RESOLVED, That the Pennsylvania Medical Society adopt the policy that appropriate due process rights must be assured to a physician who has received an adverse recommendation regarding medical staff membership or privileges from the Medical Executive Committee; and be it further

RESOLVED, That such due process rights shall include the following: (1) that an appeal must be conducted by an impartial body consisting of physicians who did not participate in the previous recommendation; and (2) if a negative action is taken by the physician hearing committee, a hearing must be held by a committee of the Board of Trustees (both already part of the revised Pennsylvania Model Medical Staff Bylaws); and be it further

RESOLVED, That the Pennsylvania Medical Society notify all Pennsylvania hospital medical staffs of the aforementioned procedure.

Mr. Speaker, your reference committee recommends that the following substitute resolution be adopted in lieu of Resolutions 91-52 and 91-53.

RESOLVED, That the Pennsylvania Medical Society adopt the policy that hospital notification of possible loss of medical staff membership must be sent by certified mail, return receipt requested; and be it further

RESOLVED, That the Pennsylvania Medical Society adopt the policy that appropriate due process rights must be assured to a physician who has received an adverse recommendation regarding medical staff membership or privileges from the Medical Executive Committee; and be it further

RESOLVED, That such due process rights shall include the following: (1) that an appeal must be conducted by an impartial body consisting of physicians who did not participate in the previous recommendation; and (2) if a negative action is taken by the physician hearing committee, a hearing must be held by a committee of the Board of Trustees; and be it further

RESOLVED, That the Pennsylvania Medical Society notify all Pennsylvania hospital medical staffs of the aforementioned procedure.

Because these two resolutions addressed similar issues, your reference committee has combined them for your consideration. Both resolutions were precipitated by a single episode. Testimony was generally sympathetic to the intent of the resolutions. The due process rights as outlined in the third resolved are already part of the revised Pennsylvania Model Medical Staff Bylaws.

It was moved and seconded from the floor of the House to add the following words to the end of the first resolved of the substitute resolution, "and that this procedure become part of the Pennsylvania Medical Society Model Hospital Medical Staff Bylaws"; this was accepted as an editorial revision.

It was moved and seconded from the floor of the House to delete from the third resolved of the substitute resolution the words, "a committee of the Board of Trustees"; this was accepted as an editorial revision.

Dr. Schragger, chairman of Reference Committee C, recommended deleting from the second resolved of the substitute resolution the words, "from the Medical Executive Committee."

It was moved and seconded from the floor of the House to postpone action on the substitute resolution until a definite time to allow the reference committee and the author of the resolution to bring back specific language to the House. The House approved the motion.

RESOLUTION 91-54: Study of Medical Staff Experiences with the National Practitioner Data Bank

RESOLVED, That the Pennsylvania Medical Society call upon its members to report the experience of medical staffs in dealing with the National Practitioner Data Bank and to document problems such as violating confidentiality, not responding promptly, and excessive fees, and to report such experiences to the Pennsylvania Medical Society which will in turn report this data to the American Medical Association.

Mr. Speaker, your reference committee recommends that Resolution 91-54 be adopted.

Resolution 91-54 calls for the Pennsylvania Medical Society to call upon its members to report the experience of medical staffs in dealing with the National Practitioner Data Bank to the Pennsylvania Medical Society which will in turn report this data to the AMA.

The House adopted Resolution 91-54.

RECOMMENDATION 2a, ADDRESS OF THE PRESIDENT ELECT: Continue Pursuing the Society's Indigent Care Plan, Working to Implement Portions of the Plan as Practical

Mr. Speaker, your reference committee recommends that Recommendation 2a be adopted.

The president elect recommended in his address that the Society take certain steps in the public health arena. Of the four steps recommended, your reference committee concurs with continued pursuit of the Society's indigent care plan.

The House adopted Recommendation 2a.

RECOMMENDATION 7d, ADDRESS OF THE PRESIDENT ELECT: Pursuing Procedural Safeguards in the Pro Process

Mr. Speaker, your reference committee

recommends that Recommendation 7d be adopted.

The president elect outlined in his address four specific recommendations to decrease the physician hassle factor. Your reference committee agrees with the recommendation specific to pursuing procedural safeguards in the PRO process.

The House adopted Recommendation 7d.

REPORT L, BOARD OF TRUSTEES: SUBSTITUTE RESOLUTION 89-24, Mandated Appeals Mechanism for Physicians

Mr. Speaker, your reference committee recommends that Board of Trustees Report L be adopted.

Report L, Board of Trustees: Substitute Resolution 89-24 directed the Society to study the following proposal: "All physicians participating in mandated health care systems must be afforded an appeals mechanism for a specific medically necessary test or therapy if denied by the insurer/employer."

It was moved and seconded from the floor of the House that Resolution 89-24 be adopted in lieu of Board Report L. The House adopted Resolution 89-24.

REPORT T, BOARD OF TRUSTEES: RESOLUTION 90-48, Reporting of Pennsylvania Hospitals' Annual Advertising Costs to the Health Care Cost Containment Council

Mr. Speaker, your reference committee recommends that Board of Trustees Report T be adopted.

Report T, Board of Trustees: Resolution 90-48 directed that the annual cost of advertising for each of the hospitals in Pennsylvania be reported to the Pennsylvania Health Care Cost Containment Council and appear as a separate entity in the Pennsylvania Health Care Cost Containment Council's hospital financial report.

Your reference committee heard testimony in support and opposition to this resolution. Although it would be desirable to have access to this kind of data, hospitals are not uniform in their definition of what is included in advertising costs.

It was moved and seconded from the floor of the House to refer back to the Board Report T. The House approved referring Board Report T.

REPORT RR, BOARD OF TRUSTEES: Neuroleptic Drug Use in Nursing Homes

Mr. Speaker, your reference committee recommends that Board of Trustees Report RR be adopted.

Report RR, Board of Trustees calls on Pennsylvania Medical Society, in cooperation with the American Medical Association, to seek a comprehensive revision of HCFA guidelines governing the use of psychotropic drugs in nursing homes.

It was moved and seconded from the floor of the House to amend the reference committee recommendation by adding that Board Report RR be referred to the AMA Delegation for implementation. The House approved the amendment. The House adopted Board Report RR and referred it to the AMA Delegation for implementation.

Waiver of debate list

The following items have been grouped together in a waiver of debate list; little or no testimony was heard, and the committee feels that the items are of noncontroversial nature.

Mr. Speaker, your reference committee recommends that the following nine items be filed:

REPORT F, BOARD OF TRUSTEES: AMENDED RESOLUTION 90-25, Procurement of Medical Records

REPORT H, BOARD OF TRUSTEES: RECOMMENDATION 6 of the President Elect, Occupational Medicine

REPORT O, BOARD OF TRUSTEES: Task Force on Federally Mandated Peer Review Cost Effectiveness

REPORT U, BOARD OF TRUSTEES: RESOLUTION 89-19, KePRO's Activities in the Small Area Analysis Feedback Map Program

REPORT LL, BOARD OF TRUSTEES: Task Force on Health Care Cost Containment

REPORT QQ, BOARD OF TRUSTEES: HAP/Pennsylvania Medical Society /POMA Joint Committee on Health Care Data

REPORT A, COUNCIL ON MEDICAL PRACTICE

REPORT A, HOSPITAL MEDICAL STAFF SECTION (HMSS)

REPORT A, KEYSTONE PEER REVIEW ORGANIZATION (KePRO)

The House approved filing the waiver of debate items.

Nominations and Elections

In accordance with Standing Rule 10 (adopted October 22, 1982), nominations of delegates to the AMA were held Friday morning, October 18, 1991, and elections were held Saturday morning, October 19, 1991. Nominations for all other offices were held on Saturday, October 19, 1991, and voting for those offices contested was held Sunday morning, October 20, 1991. As mandated by Resolution 89-2, Publishing the Results of Elections, the following is an account of those elections. The new officers for 1991-92 are:

President: Robert N. Moyers, MD (Crawford) was installed as the president.

President Elect: Donald G. Ferguson, MD (Allegheny) acceded to the office of president elect.

Vice President: Martin A. Murcek, MD (Westmoreland) was elected to the office of vice president with 153 votes; Irving Williams, III, MD (Union) received 103 votes.

Speaker: Jonathan E. Rhoads, Jr., MD (York) was elected by acclamation as speaker.

Vice Speaker: Howard A. Richter, MD (Delaware) was elected by acclamation as vice speaker.

The following trustees were elected by acclamation:

Seventh District: William R. Beltz, MD (Lycoming)

Twelfth District: Victor F. Greco, MD (Luzerne)

Interspecialty Section: James R. Regan, MD

Resident Physicians: Daniel S. Henriksen, MD

Young Physicians: Richard J. Greco, MD

Medical Students: Mark V. Caliendo

Elections were held for the following contested positions:

Sixth District: Edward H. Dench, Jr., MD (Centre) was elected with 183 votes; Augusto N. Delerme, MD (Blair) received 74 votes.

Tenth District: John W. Lehman, MD (Beaver) was elected with 132 votes; George F. Buerger Jr., MD (Allegheny) received 124 votes.

Matthew Marshall Jr., MD (Allegheny), was reelected by acclamation to serve a three-year term on the Committee to Nominate Delegates and Alternates to the AMA. Donald E. Parlee, MD (Bucks), was elected to serve a three-year term on the Committee to Nominate Delegates and Alternates to the AMA with 141 votes; Gerald L. Andriole, MD (Luzerne), received 83 votes; and Joanne S. Zenker, MD (Lackawanna), received 32 votes.

Raymond C. Grandon, MD (Dauphin), was reelected to a three-year term on the Pennsylvania Medical Society Judicial Council with 170 votes; Frank J. Tornetta, MD (Montgomery), received 63 votes; and G. Winfield Yarnall, MD (Dauphin), received 23 votes. David W. Clare, MD (Allegheny), was elected to a three-year term on the Pennsylvania Medical Society Judicial Council with 118 votes; Robert S. Sanford, MD (Tioga), received 77 votes; and Wilbur E. Flannery, MD (Lawrence), received 61 votes.

Report of the Committee to Nominate Delegates and Alternates to the AMA

The nominations of the Committee to Nominate Delegates and Alternates to the American Medical Association were published on pages 1 and 2 of the *Official Reports Book*. The following were nominated for 12 two-year AMA delegate positions beginning January 1, 1992, and expiring December 31, 1993, and for one one-year term beginning January 1, 1992, and expiring December 31, 1992. The persons receiving the 12 highest number

of votes were elected to the two-year terms, and the person receiving the thirteenth highest number of votes was elected to the one-year term: Donald C. Brown, MD (Westmoreland-239 votes); Ronald J. Clearfield, MD (Westmoreland-236 votes); Donald G. Ferguson, MD (Allegheny-227 votes); George R. Fisher III, MD (Philadelphia-222 votes); Robert L. Lasher, MD (Erie-215 votes); William H. Mahood, MD (Montgomery-247 votes); Robert N. Moyers, MD (Crawford-246 votes); Lewis T. Patterson, MD (Dauphin-195 votes); Michael J. Prendergast, MD (York-231 votes); Robert D. Reinecke, MD (Philadelphia-191 votes); Jonathan E. Rhoads Jr., MD (York-239 votes); and Barbara A. Shelton, MD (Philadelphia-215 votes). Joseph N. Demko, MD (Lackawanna), was elected to the one-year term with 183 votes.

The following is an account of the votes received by those not elected to AMA delegate positions: Gerald L. Andriole, MD (Luzerne-182 votes); Charles A. Heisterkamp, III, MD (Lancaster-80 votes); and Gordon K. MacLeod, MD (Allegheny-154 votes).

The following were nominated for 12 two-year AMA alternate delegate positions beginning January 1, 1992, and expiring December 31, 1993, and for two one-and-one-half year terms beginning October 20, 1991, and expiring December 31, 1992. The persons receiving the 12 highest number of votes were elected to the two-year terms, and the persons receiving the thirteenth and fourteenth highest number of votes were elected to the one-and-one-half year terms: Brenda K. Baumann, MD (Luzerne-239 votes); Richard T. Bell, MD (Berks-253 votes); George F. Buerger Jr., MD (Allegheny-249 votes); David L. Cohen, MD (York-234 votes); James L. Cristol, MD (Philadelphia-229 votes); Jay L. Funkhouser, MD (Beaver-239 votes); Joseph A.C. Girone, MD (Bucks-244 votes); William W. Lander, MD (Montgomery-216 votes); John W. Lehman, MD (Beaver-238 votes); Leland F. Patterson, MD (Dauphin-252 votes); Carol E. Rose, MD (Allegheny-244 votes); and J. Walter Valenteen, MD (Delaware-240 votes). Elias Abrutyn, MD (Philadelphia-200 votes), and John D. Lane, MD (Bucks-197 votes), were elected to the two one-and-one-half year terms.

The following is an account of the votes received by those not elected to AMA alternate delegate positions: Charles A. Heisterkamp III, MD (Lancaster-119 votes), and Dinesh C. Khera, MD (Erie-177 votes).

James M. Brian was elected by acclamation to the slotted AMA alternate delegate position for a medical student for a one-year term beginning January 1, 1992, and expiring December 31, 1992. Thomas F. Freenock Jr., MD was elected by acclamation to the slotted AMA alternate delegate position for a resident physician for a one-year term beginning January 1, 1992, and expiring December 31, 1992.

Reference Committee D

Presented by:
Carol E. Rose, MD

Mr. Speaker, members of the House of Delegates, Reference Committee D has considered all of the items in the index.

REPORT K, BOARD OF TRUSTEES: REPORT F: RESOLUTION 89-60: Advertisement Encouraging the Filing of Malpractice Lawsuits

Mr. Speaker, your reference committee recommends that Report K, Board of Trustees be adopted.

This report dealt with inappropriate advertisements soliciting the filing of malpractice suits against physicians. Although no testimony was heard, the committee notes that "endeavors to resolve this issue satisfactorily" will continue and we look forward to future updated reports to the House of Delegates.

The House adopted Board Report K.

REPORT M, BOARD OF TRUSTEES: AMENDED SUBSTITUTE RESOLUTION 90-57: Amendments to Medicare Fee Control Act

Mr. Speaker, your reference committee recommends that Report M, Board of Trustees be adopted.

The committee heard no testimony and appreciates that state legislation has been introduced relating to a means test (Senate Bill 458) and that the RBRVS regulations may address the geographic charge issue.

The House adopted Board Report M.

RESOLUTION 91-1: Scope of Psychological Practice in the Hospital Setting

RESOLVED, That the Pennsylvania Medical Society adopt the following positions to be used to guide Pennsylvania Medical Society representatives and staff in considering and responding to legislative and regulatory initiatives addressing the scope of psychological practice in the hospital setting.

(1) A psychologist with clinical duties may, with the concurrence of any psychiatric member of the medical staff, recommend patients for admission. The attending psychiatrist shall assume responsibility and authority for the care of the patient throughout the hospital stay, including the collaborative participation of the recommending psychologist. The extent and nature of the collaboration should be determined by the Bylaws of the individual hospital in accordance with existing regulations;

(2) Psychologists should be included as voting members on committees where appropriate and not in conflict with the Bylaws of the individual hospital;

(3) "Psychologists" in this regard shall be defined as licensed, clinical, doctoral-level psychologists operating within the scope of their license; and

(4) Efforts to enlarge upon the role of psychologists in hospitals beyond these areas shall be opposed by the Pennsylvania Medical Society as not in the interest of the best health care for the citizens of Pennsylvania.

Mr. Speaker, your reference committee recommends that Resolution 91-1 be adopted.

This resolution deals with threatened legislative and regulatory changes designed to broaden the hospital privileges of psychologists. Testimony by several psychiatrists supported adoption of this resolution. We agree that these policies would serve to protect patients appropriately.

The House adopted Resolution 91-1.

RESOLUTION 91-24: Pennsylvania Medical Society 's Legislative Lobbying Organization

RESOLVED, That the Pennsylvania Medical Society seek immediate restructuring of its present lobbying organization to better meet the needs and goals of physicians.

Mr. Speaker, your reference committee recommends that Resolution 91-24 be amended as follows:

RESOLVED, That the Pennsylvania Medical Society [seek immediate restructuring] *review and evaluate* [of] its present lobbying [organization] *process* to better meet the needs and goals of physicians and to facilitate the education of our members with regard to this process.

Mr. Speaker, your reference committee recommends that Resolution 91-24 be adopted as amended.

In view of the recent restructuring of the Society's lobbying staff, the original intent of this resolution has been addressed. Testimony supports the above amendment because increased emphasis is needed on physician education and participation.

The House adopted as amended Resolution 91-24.

RESOLUTION 91-47: Transfer of Funds from the Federal Defense Budget to Health Care Needs

RESOLVED, That the Pennsylvania Medical Society send a letter to President Bush and to the Majority and Minority leaders of the House of Representatives and Senate, requesting that by mutual consent they revise last year's budget agreement and permit some of the defense funds made available by the lessening Soviet threat to be transferred to childhood immunization programs, to AIDS research and treatment, and to an adequate Medicare budget.

Mr. Speaker, your reference committee recommends that Resolution 91-47 be amended as follows:

RESOLVED, That the Pennsylvania Medical Society send a letter to President

Bush, [and to] the Majority and Minority leaders of the [House of Representatives and Senate] *U.S. Congress and the Pennsylvania Congressional delegation*, requesting that by mutual consent they revise last year's budget agreement and permit some of the defense funds made available by the lessening Soviet threat to be transferred to childhood immunization programs, to AIDS research and treatment, and to [an adequate] *the* Medicare budget.

Mr. Speaker, your reference committee recommends that Resolution 91-47 be adopted as amended.

Although we heard testimony only from a sponsor of this resolution, we agree that any movement in this direction would be beneficial.

The House adopted as amended Resolution 91-47.

RECOMMENDATION 5 OF THE PRESIDENT ELECT: Joint Committee with the American Association of Retired Persons

Mr. Speaker, your reference committee recommends that Recommendation 5 of the President Elect be adopted.

The committee believes that this proposal should be strongly endorsed, because a coalition between medicine and the AARP would be beneficial to both groups.

It was moved and seconded from the floor of the House to refer Recommendation 5. The House did not approve the motion. The House adopted Recommendation 5.

RECOMMENDATION 6 OF THE PRESIDENT ELECT: Meetings with Congressional Legislative Assistants

Mr. Speaker, your reference committee recommends that Recommendation 6 of the President Elect be adopted.

This recommendation is an appropriate expansion of the Society's current Federal Key Contact program and will enhance a lobbying effort by physicians which has already been recognized as a model among the states.

The House adopted Recommendation 6.

Waiver of debate list

The following items have been grouped together in a waiver of debate list; no testimony was heard, and the committee feels that the items are of a noncontroversial nature.

Mr. Speaker, your reference committee recommends that the following item be adopted:

RESOLUTION 91-19: Tort Reform

RESOLVED, That the Pennsylvania Medical Society continue its high priority efforts to promote meaningful tort reform in Pennsylvania.

The House adopted the waiver of debate item.

Mr. Speaker, your reference committee recommends that the following three items be filed:

REPORT A, COUNCIL ON GOVERNMENTAL RELATIONS

REPORT A, PENNSYLVANIA MEDICAL POLITICAL ACTION COMMITTEE

REPORT II, BOARD OF TRUSTEES: Auto Insurance and Medicare Balance Billing Litigation

The House approved filing the waiver of debate items.

Recess

The House of Delegates recessed at 4:50 p.m. for the inaugural program and reception.

Inaugural Program and Reception

The inaugural program was held at 6:30 p.m. in the Exhibit Center of the Adam's Mark Hotel, Philadelphia.

Opening remarks—Jonathan E. Rhoads Jr., MD, speaker of the House of Delegates, presented opening remarks.

Master of Ceremonies—John H. Hobart, MD, chairman of the Pennsylvania Medical Society Board of Trustees, presided as the master of ceremonies.



Prior to his inauguration, new Society President Robert N. Moyers, MD, outlined challenges facing physicians in the year to come.

Invocation—The invocation was presented by The Reverend Christopher A. Fuji and The Reverend Penney A. Fuji of the Fifth Street Presbyterian Church of Conneaut Lake.

Pledge of Allegiance—John H. Hobart, MD, led the attendees in the pledge of allegiance.

Singing of "The National Anthem"—"The National Anthem" was sung by Susan Katz.

Introductions—John H. Hobart, MD, made the following introductions: Pennsylvania Medical Society officers and trustees; Pennsylvania Medical Society past presidents; Pennsylvania Medical Society Auxiliary president and immediate past president; auxiliary dignitaries and Board of Directors; and visiting dignitaries.

Presentation of Plaques to Retiring Leaders—John H. Hobart, MD, presented plaques to Brenda K. Baumann, MD; Betty L. Cottle, MD; Martin A. Murcek, MD; Steven F. Nemerson; Carl A. Sirio, MD; and Irving Williams III, MD.

Presentation of Past President's Medallion—John H. Hobart, MD, presented the past president's medallion to Gordon K. MacLeod, MD, Allegheny County, as the 141st president.

Installation of the President—John H. Hobart, MD, installed Robert N. Moyers, MD, Crawford County, as the 142nd president of the Pennsylvania Medical Society. After taking the oath of office, Dr. Moyers delivered brief remarks.

Closing remarks—Jonathan E. Rhoads Jr., MD, presented closing remarks. Following the program, a reception was held in Grand Ballrooms A-F.

Final Session

October 20, 1991

The final session of the 1991 House of Delegates was called to order at 9:06 a.m. in the Exhibit Center of the Adam's Mark Hotel, Philadelphia.

Credentials Committee

Charles D. Tourtellotte, MD, presented the following report.

Mr. Speaker, there is a quorum of 274 delegates registered and in attendance today.

Reference Committee C

Presented by:
Alan H. Schragger, MD

RESOLUTION 91-52: Proper Notification of a Physician Regarding Possible Loss of Medical Staff Membership or Privileges

RESOLVED, That the Pennsylvania Medical Society adopt the policy that hospital notification of possible loss of medical staff membership must be sent by certified mail, return receipt requested; and be it further

RESOLVED, That the Pennsylvania Medical Society adopt the policy that an appropriate appeals process (such as that which is written in the Pennsylvania Medical Society Model Medical Staff Bylaws) for possible loss of medical staff membership for any reason must be part of the medical staff Bylaws; and be it further

RESOLVED, That the aforementioned procedure must be included in the Pennsylvania Medical Society Model Medical Staff Bylaws; and be it further

RESOLVED, That the existence of the aforementioned procedure must be communicated to all Pennsylvania hospital medical staffs.

RESOLUTION 91-53: Appropriate Appeals Procedure Following Recommendation by the Medical Executive Committee Regarding Loss of Medical Staff Membership or Privileges

RESOLVED, That the Pennsylvania

Medical Society adopt the policy that appropriate due process rights must be assured to a physician who has received an adverse recommendation regarding medical staff membership or privileges from the Medical Executive Committee; and be it further

RESOLVED, That such due process rights shall include the following: (1) that an appeal must be conducted by an impartial body consisting of physicians who did not participate in the previous recommendation; and (2) if a negative action is taken by the physician hearing committee, a hearing must be held by a committee of the Board of Trustees (both already part of the revised Pennsylvania Model Medical Staff Bylaws); and be it further

RESOLVED, That the Pennsylvania Medical Society notify all Pennsylvania hospital medical staffs of the aforementioned procedure.

Mr. Speaker, your reference committee recommends that the following amended substitute resolution be adopted in lieu of Resolutions 91-52 and 91-53.

RESOLVED, That the Pennsylvania Medical Society adopt the policy that hospital notification of possible loss of medical staff membership must be sent by certified mail, return receipt requested; and that this procedure become part of the Pennsylvania Medical Society Model Medical Staff Bylaws; and be it further

RESOLVED, That the Pennsylvania Medical Society adopt the policy that appropriate due process rights must be assured to a physician who has received an adverse recommendation regarding medical staff membership or privileges [from the Medical Executive Committee]; and be it further

RESOLVED, That such due process rights shall include the following: (1) that an appeal must be conducted by an impartial body consisting of physicians who did not participate in the previous recommendation; and (2) if a negative action is taken by the physician hearing committee, a hearing must be held by a committee of the [Board of Trustees] hospital governing body; and be it further

RESOLVED, That the Pennsylvania Medical Society notify all Pennsylvania hospital medical staffs of the aforementioned procedure.

The House adopted the amended substitute resolution.

Reference Committee E

Presented by:
Donald H. Smith, MD

Mr. Speaker, members of the House of Delegates, Reference Committee E has considered all of the items in the index.

REPORT A, COUNCIL ON MEDICAL ECONOMICS: Referrals from 1990 House of Delegates

Mr. Speaker, your reference committee recommends that Report A be referred to the Board of Trustees for further action.

Report A outlines the accomplishments and activities of the Council on Medical Economics and includes reports on the status of implementation of resolutions of the 1990 House of Delegates.

Resolution 90-38 directed the Society to go on record as recommending that prepaid prescription plans allow participants to receive prescriptions for drugs in quantities smaller than a three-month supply.

Your reference committee received testimony indicating the Society's efforts to seek changes from the State Board of Pharmacy, but feels additional action is necessary to address the intent of this resolution.

Several portions of Report A referred to ongoing activities of the Society to review and evaluate third-party plans and contracts. Your reference committee heard considerable testimony regarding the need for analysis and information pertaining to individual physicians' rights and responsibilities under plans of this type. Testimony reflected concern that the Society needed, through its various administrative components, to provide additional support for physicians in this area.

The House approved referring Report A.

RESOLUTION 91-2: Practice Parameters

RESOLVED, That the Pennsylvania Medical Society recognize and approve the further development of practice parameters through appropriate specialty societies in conjunction with the American Medical Association; and be it further

RESOLVED, That the Pennsylvania Medical Society continue educating its membership about the current and future trends in practice parameters in not only clinical practice, but in residency and medical school training programs.

Mr. Speaker, your reference committee recommends that the first resolved of Resolution 91-2 be amended as follows:

RESOLVED, That the Pennsylvania Medical Society recognize and [approve] *support* the further development of practice parameters through appropriate specialty societies in conjunction with the American Medical Association;

Mr. Speaker, your reference committee recommends that Resolution 91-2 be adopted as amended.

Resolution 91-2 directs the Society to develop a process for the development, recognition, and approval of practice parameters for medical care.

Your reference committee heard testimony on current efforts at the national level by the American Medical Association and the national specialty societies to establish and disseminate appropriate practice parameters. The difficulty and the potential expense of initiating development of such parameters at the state level was discussed. It was felt that the first resolved of the resolution should reflect the need for the Society to use existing structural mechanisms in carrying out this task.

The House adopted as amended Resolution 91-2.

REPORT N, BOARD OF TRUSTEES: Standards of Medical Practice (RESOLUTION 90-33)

Mr. Speaker, your reference committee recommends that Report N be referred to the Board of Trustees for further study.

Report N responds to Resolution 90-33 which called on the Society to take an active role in recommending approval of new procedures for acceptance for reimbursement purposes by third parties.

Your reference committee heard testimony from representatives of Blue Cross and Blue Shield dealing with the experimental status of new procedures and services for reimbursement. The Blue Cross criteria includes the recognition of procedures by appropriate regulatory agencies; accumulation of research data and reports; selection of the best treatment alternative; and the need to improve the net outcome of care.

Your reference committee commends Blue Cross and Blue Shield for their efforts in this regard to date, but feels there is still room for improving and expediting this process.

The House approved referring Board Report N.

REPORT Q, BOARD OF TRUSTEES: Third-Party Utilization Review (RESOLUTION 90-63)

Mr. Speaker, your reference committee recommends that Report Q be referred to the Board of Trustees for further study.

Report Q outlines the history of the Society's efforts in the area of peer and utilization review. It concludes that, given the current legal climate, the Society should not engage in such activities.

Your reference committee, despite receiving no testimony, felt that a discrepancy exists between the substance of Resolution 90-63 and the report. Therefore, additional study of the problem and exploration of alternative approaches should be undertaken.

The House approved referring Board Report Q.

RESOLUTION 91-14: Geriatrics as Valid Medical Specialty for Medicare

RESOLVED, That the Pennsylvania Medical Society encourage Pennsylvania Blue Shield to declare that *geriatrics* is a valid medical specialty for Medicare in the state of Pennsylvania.

Mr. Speaker, your reference committee recommends that Resolution 91-14 not be adopted.

Resolution 91-14 requests Pennsylvania Blue Shield to recognize geriatrics as a specialty for reimbursement purposes.

Your reference committee heard testimony that the implementation of the Medicare Physician Payment System in 1992 will do away with differences in payout by specialty. It was further

indicated that Blue Shield currently has a procedure for recognition of specialties which includes the existence of the national certification board with certification examination. Currently, geriatrics is recognized by the granting of a certificate of additional training, but is not recognized by a national specialty certifying board.

It was moved and seconded from the floor of the House to refer Resolution 91-14 to the Board of Trustees for study. The House approved referring Resolution 91-14.

REPORT SS, BOARD OF TRUSTEES: Worker's Compensation Reform

Mr. Speaker, your reference committee recommends that Report SS be filed.

Report SS outlines the status of the Society's activities with respect to seeking reform to the Commonwealth's workers' compensation system.

Your reference committee wishes to commend the Board of Trustees for its prompt and ongoing action to address this emerging issue.

The House approved filing Board Report SS.

REPORT ZZ, BOARD OF TRUSTEES: Auto Insurance Reform (ACT 6)

Mr. Speaker, your reference committee recommends that Report ZZ be filed.

Report ZZ addresses the efforts of the Society to respond to the enactment of the Automobile Insurance Reform Act and its implementing regulations.

Your reference committee commends the Board of Trustees for its ongoing activities to mitigate the negative impact of the Act and its regulations.

The House approved filing Board Report ZZ.

RESOLUTION 91-21: Medical Assistance Participation

RESOLVED, That the Pennsylvania Medical Society work in concert with the Department of Public Welfare and the Department of Health to orchestrate a program of increased compensation for physicians, especially in those areas where the need for service is demonstrated to be the greatest.

Mr. Speaker, your reference committee recommends that the first resolved of Resolution 91-21 be amended as follows:

RESOLVED, That the Pennsylvania Medical Society work in concert with the Department of Public Welfare [and], the Department of Health, *and the Pennsylvania General Assembly* to orchestrate a program [of increased compensation for physicians, especially in those areas where the need for service is demonstrated to be the greatest.] *to expand coverage under Medicaid to those citizens of the Commonwealth who qualify under the federal definition of poverty; to increase access to medical care for beneficiaries; and to allow for appropriate compensation for providers.*

Mr. Speaker, your reference committee recommends that Resolution 91-21 be adopted as amended.

Resolution 91-21 addresses the current plight of the medically indigent and uninsured/underinsured population in Pennsylvania and calls for the Society to seek improvements.

Your reference committee heard testimony on the Society's current efforts to work with the Office of Medical Assistance, Department of Public Welfare and members of the Pennsylvania General Assembly to improve the existing Medical Assistance Program and to expand health care coverage to the additional 1.7 million people without adequate health benefits.

It was moved and seconded from the floor of the House to further amend the first resolved of Resolution 91-21 by deleting the words, "under the federal definition of poverty", and deleting the words, "allow for appropriate compensation for providers." and inserting the words, "remove administrative and financial barriers to provider participation." The House approved the amendments.

It was moved and seconded from the floor of the House to refer to the Board of Trustees for action amended Resolution 91-21. The House approved referring amended Resolution 91-21.

RESOLUTION 91-13: [Efforts to Improve Care and Control Costs] *Federal Restrictions for Long-Term Care*

RESOLVED, That the Pennsylvania Medical Society support efforts to reduce the burden of federal regulations and oversight regarding the provision of long-term care; and be it further

RESOLVED, That a similar resolution be considered by the Pennsylvania Delegation to the American Medical Association for submission at the national level.

Mr. Speaker, your reference committee recommends that the first resolved of Resolution 91-13 be amended as follows:

RESOLVED, That the Pennsylvania Medical Society support efforts to reduce the burden of federal [regulations] *restrictions* and *federal and state* oversight regarding the provision of long term care;

Mr. Speaker, your reference committee recommends that Resolution 91-13 be adopted as amended.

Resolution 91-13 calls for the Society to work to lessen the constraints of federal law and regulations on the delivery of long term care.

Your reference committee understands a portion of the problem relates to the law while other restrictions are contained in regulations. Testimony addressed the negative impact of such restrictions of quality care to patients in long term facilities.

It was moved and seconded from the floor of the House to further amend Resolution 91-13 by substituting the second resolved with the following, "RESOLVED, That the American Medical Association support legislation to reduce federal control of long-term care so that the individual states would be empowered to devise and experiment with various strategies in the financing and provision of long-term care." The House approved the substitute. The House adopted as amended Resolution 91-13.

RECOMMENDATION 2b, ADDRESS OF PRESIDENT ELECT: Supporting AMA's Health Access America

Mr. Speaker, your reference committee recommends that Recommendation 2b of the address of the President Elect (Robert N. Moyers, MD) be filed.

Recommendation 2b calls on the Society to continue its support of the American Medical Association's Health Access America initiative.

Your reference committee wishes to commend the President Elect (Dr. Moyers) for keeping the AMA initiative before the Society as a basic policy for addressing issues related to access to health care.

The House approved filing Recommendation 2b.

RECOMMENDATION 7, ADDRESS OF THE PRESIDENT ELECT: RBRVS and Medicare Fee Schedule Changes

Mr. Speaker, your reference committee recommends that Recommendation 7 of the address of the President Elect (Robert N. Moyers, MD) be filed.

Recommendation 7 contains the following provisions: (a) development of capabilities to assist members to prepare for and deal with the Medicare Physician Payment System; (b) strengthening efforts to achieve utilization of the Health Care Financing Administration (HCFA) form 1500 for all claims; and (c) pursuit of legislation mandating reasonable payment timeframes.

Filing is recommended since these recommendations are consistent with ongoing Society policy and activities.

The House approved filing Recommendation 7.

Waiver of debate list

The following items have been grouped together in a waiver of debate list; no testimony was heard, and the committee feels the items are of a noncontroversial nature.

Mr. Speaker, your reference committee recommends for adoption:

REPORT R, BOARD OF TRUSTEES: Level II PA Blue Shield Fees (RESOLUTION 90-73)

RESOLUTION 91-33: Automatic Processing of Major Medical Claims

RESOLVED, That the Pennsylvania Medical Society draft proposed legislation to mandate automatic processing of Major Medical claims and identify sponsors to introduce the legislation; and be it further

RESOLVED, That the Pennsylvania Medical Society take whatever other steps are necessary to have Pennsylvania legislate mandatory automatic processing of Major Medical claims.

RESOLUTION 91-44: Explanation of Payments by Health Insurers

RESOLVED, That the Pennsylvania Medical Society work toward state legislation requiring any and all insurance companies conducting health insurance business within the Commonwealth of Pennsylvania to itemize and encode, on their "Explanation of Payments," all payments made to medical providers in the same way that medical providers are required to itemize and encode their claims for payment.

RESOLUTION 91-16: Medicaid Reform in House Bill 20

RESOLVED, That the Pennsylvania Medical Society investigate the possibility of having private insurers bid to provide insurance to Medicaid recipients.

RESOLUTION 91-51: [Proposed] *Legislative Action to Oppose* Elimination of Professional Component Reimbursement for EKG Interpretation

RESOLVED, That the Pennsylvania Medical Society urge each of its members to petition their representative to cosponsor HR 3373, prime sponsor, Tom McMillen (D-MD), or other such legislation.

REPORT YY, BOARD OF TRUSTEES: Resource Based Relative Value Study (RBRVS)

The House adopted the waiver of debate items.

Mr. Speaker, your reference committee recommends for filing:

REPORT P, BOARD OF TRUSTEES: Exploring New Relationships with a Variety of Insurance Companies (Recommendations of the President Elect [Gordon K. MacLeod, MD])

The House approved filing the waiver of debate item.

Reference Committee G

Presented by:
Howard L. Carbaugh, MD

Mr. Speaker, members of the House of Delegates, Reference Committee G has considered all the items in the index.

REPORT TT, BOARD OF TRUSTEES: Preoperative HIV Testing on Patients (RESOLUTION 90-50)

RESOLUTION 91-15: Mandatory HIV Testing

RESOLVED, That the Pennsylvania Medical Society continue to serve as a voice of reason and leadership and oppose across-the-board mandatory HIV testing of health care workers as well as across-the-board HIV testing of patients without their consent, except in the limited cases where current Pennsylvania law allows testing without consent; and be it further

RESOLVED, That the Pennsylvania Medical Society continue its advocacy of appropriate voluntary HIV testing for all Pennsylvanians at risk including health care workers; and be it further

RESOLVED, That the Pennsylvania Medical Society continue to support the concept of peer consultation and supervision of HIV- infected health care workers in order to appropriately protect patients.

RESOLUTION 91-11: HIV Testing of Providers

RESOLVED, That the Pennsylvania Medical Society support the position that physicians in the state of Pennsylvania need not heed the AMA and other groups' demands that they reveal their HIV status to their patients or that they restrict their care to their patients in inner respect, including the invasive procedures, provided that they utilize universal precautions; and be it further

RESOLVED, That the Pennsylvania Medical Society push for reforms in the area of HIV testing so that it can be more easily accomplished and that those results, if positive, be reported to the State Board of Health for tracking and contact identification.

RESOLUTION 91-38: AIDS/HIV Testing

RESOLVED, That the Pennsylvania Medical Society urge our legislators to:

(1) allow for unlimited and unrestricted testing for HIV whenever it appears to be medically appropriate in order to reduce the rate of spread of this incurable disease among the general population and to begin early treatment so as to delay the onset of symptoms in the individual patient who is as yet asymptomatic; and

(2) require reporting of all HIV positivity to the State Department of Health those unfortunate victims who have contracted the disease, and at the same time require confidentiality so as to avoid persecution in the workplace and unnecessary hardship in the patient's social environment.

RESOLUTION 91-42: HIV Testing

RESOLVED, That medical personnel involved in invasive procedures may legally and ethically request pre-procedure HIV testing; and be it further

RESOLVED, That appropriate measures be taken to protect the health care worker as with syphilis, hepatitis B, tuberculosis, or any other infectious disease; and be it further

RESOLVED, That the Pennsylvania Medical Society lobby the Pennsylvania legislature to adopt an AIDS Discovery Law.

Mr. Speaker, your reference committee recommends that the Board policy statement contained within Board of Trustees Report TT be amended as follows:

Whenever in the judgment of a physician, AIDS testing is necessary, either for the care of the patient or the protection of health care workers, that testing should be carried out. *The value of appropriate pre-test and post-test counseling is recognized.* Efforts to educate the public, the legal profession, and the legislators as to the reasonableness of this approach should be expanded.

Mr. Speaker, your reference committee recommends that Report TT, as amended, be adopted in lieu of Resolutions 91-15, 91-11, 91-38, and 91-42.

Report TT responds to Resolution 90-50 calling for the Pennsylvania Medical Society to recommend HIV testing for all pre-operative patients. The Board of Trustees adopted a policy calling for testing at the physician's discretion implying that informed consent not be required. Since testing is performed at the physician's discretion, it may not always be appropriate to test all pre-operative patients, so the physician is free to decide when to test.

Resolution 91-15 calls for the Pennsylvania Medical Society to continue to oppose across-the-board mandatory HIV testing for patients or physicians. It calls for continuation of policies which call for voluntary testing of all members of high-risk groups including physicians. It also calls for continued support for peer consultation and supervision of HIV-infected health care workers.

The purpose of Resolution 91-11 is to have the Pennsylvania Medical Society oppose the American Medical Association's position calling for HIV-infected physicians to inform their patients of their infection prior to performing invasive procedures. In addition, the resolution calls for the Pennsylvania Medical Society to seek reform in the area of HIV testing to make testing easier and to assure that positive results are reported to public health authorities.

Two resolveds are included in Resolution 91-38. The first calls for the State Society to urge legislators to allow for unlimited and unrestricted testing for HIV. The second calls for the Pennsylvania Medical Society to support reporting of all HIV positive test results to the Pennsylvania Department of Health with appropriate safeguards to protect patient confidentiality.

Resolution 91-42 calls upon the Pennsylvania Medical Society to support the position that medical personnel may ethically and legally request pre-procedure HIV testing. It calls for all appropriate measures to be taken to protect health care workers from HIV, as with any other infectious disease. Finally, it calls for the State Society to lobby the Pennsylvania legislature to adopt an AIDS discovery law.

All of these items address similar

issues, and your reference committee has combined them for your consideration. All deal with the debate surrounding HIV testing. Your reference committee believes that the adoption of Report TT as amended addresses all of these issues adequately. Your reference committee wishes to point out that pre- and post-test counseling for HIV testing is still important and in the best interest of the patient.

It was moved and seconded from the floor of the House to further amend the policy statement contained in Board Report TT by inserting after the words, "either for the care of the patient or the protection of", the words, "the public and" The House approved the amendment.

It was moved and seconded from the floor of the House to replace the word, AIDS, with the word, HIV; this was accepted as an editorial revision.

It was moved and seconded from the floor of the House to adopt Resolution 91-38. It was moved and seconded from the floor of the House to amend Resolution 91-38 by inserting in (2) of the resolved the word, "confirmed", after the words, "require reporting of all"; this was accepted as an editorial revision. The House adopted as editorially revised Resolution 91-38.

It was moved and seconded from the floor of the House to adopt Resolution 91-15. It was moved and seconded from the floor of the House to amend Resolution 91-15 by replacing the three resolveds with the following, "RESOLVED, That the Pennsylvania Medical Society is against unwarranted mandatory testing." The House did not approve the amendment. The House did not adopt Resolution 91-15. The House adopted as amended Board Report TT in lieu of Resolutions 91-15, 91-11, and 91-42.

REPORT J, BOARD OF TRUSTEES: AIDS/HIV Testing (RESOLUTION 90-80)

Mr. Speaker, your reference committee recommends that Board of Trustees Report J be adopted.

Report J was created in response to Resolution 90-80 calling for removal of informed consent requirements for HIV testing and reporting of the results to public health authorities. The report outlines the actions of the Council on Governmental Relations in the difficult negotiating process which resulted in the AIDS Confidentiality Law. This law did include testing without consent if a health care worker was exposed to the patient's blood.

Your reference committee heard very little testimony regarding this report. That which was heard was not critical of the report, and your reference committee believes that Report J adequately addresses the substance of Resolution 90-80.

The House adopted Board Report J.

REPORT CC, BOARD OF TRUSTEES: HIV Positive Reporting (RESOLUTION 90-60)

Mr. Speaker, your reference committee recommends that Report CC be amended by adding the following sentence to the end of the report:

The Board of Trustees shall provide a report to the 1992 House of Delegates regarding the status of HIV positive test result reporting in Pennsylvania.

Mr. Speaker, your reference committee recommends that Report CC be adopted as amended.

This report was created in response to Resolution 90-60: HIV Positive Reporting which called for Pennsylvania Medical Society to recommend that all

HIV-positive test results be reported to the Commonwealth of Pennsylvania. The report points out that the Pennsylvania Medical Society has been on record supporting this position for several years.

Your reference committee was satisfied that the Board of Trustees has done all that could be done to assure that the Pennsylvania Department of Health makes HIV-positive test reporting mandatory. Since the Department of Health has promised to take this action, your reference committee believes that the House should be informed of the status of mandatory reporting in Pennsylvania.



Raymond C. Grandon, MD, Dauphin County, talks with Mrs. Michael J. Prendergast at a reception held for physicians and their spouses.

The House adopted as amended Board Report CC.

REPORT AAA, BOARD OF TRUSTEES: Pennsylvania Medical Society Policy Statement on CDC Guidelines

Mr. Speaker, your reference committee recommends that Report AAA be adopted.

The Pennsylvania Medical Society Board of Trustees created Report AAA in response to the "Recommendations for Preventing Transmission of Human Immunodeficiency Virus (HIV) and Hepatitis B Virus (HBV) to Patients During Exposure-Prone Invasive Procedures" published by the Centers for Disease Control. The Board believes that the restrictions upon infected health care workers contained in these recommendations are politically motivated and are not justified by epidemiologic data.

Your reference committee heard no debate regarding this report. The reference committee believes that the report is quite good and recommends a very reasonable policy.

The House adopted Board Report AAA.

RESOLUTION 91-63: The Compliance of Pennsylvania Physicians to CDC Guidelines on HIV Control

RESOLVED, That the Pennsylvania Medical Society HIV Task Force investigate the degree of compliance of Pennsylvania health care professionals with the CDC guidelines designed to limit the spread of HIV infection, and to investigate the effectiveness of said compliance; and be it further

RESOLVED, That the HIV Task Force of the Pennsylvania Medical Society use its findings to determine whether or not further action needs to be taken by Pennsylvania health care professionals and/or the Pennsylvania state government.

Mr. Speaker, your reference committee recommends that Resolution 91-63 not be adopted.

Resolution 91-63 calls for the Pennsylvania Medical Society to investigate the degree of compliance with CDC guidelines for preventing transmission of HIV and HBV to patients and determine whether or not additional actions are required of health care professionals or state government.

Your reference committee believes that the study called for by this resolution would be extremely difficult for the Pennsylvania Medical Society to perform. The resolution does not advocate any particular methodology.

It was moved and seconded to postpone temporarily Resolution 91-63. The House approved the motion.

RESOLUTION 91-41: Physicians with AIDS

RESOLVED, That physicians with positive serology for HIV or AIDS be reported to public health authorities; and be it further

RESOLVED, That the physician with positive serology for HIV or AIDS should be encouraged to seek employment with no direct patient contact.

Mr. Speaker, your reference committee recommends that Resolution 91-41 not be adopted.

The purpose of Resolution 91-41 is to assure that physicians who test positive for HIV or AIDS be reported to public health authorities. Its second purpose is to have the Pennsylvania Medical Society encourage HIV-positive physicians to seek employment with no direct patient contact.

Your reference committee believes that the first resolved of Resolution 91-41 is

already addressed by State Society policy calling for all HIV-positive test results to be reported to public health authorities. The majority of testimony heard by your reference committee was in opposition to the second resolved in this report and it appears to conflict with Report AAA of the Board of Trustees.

The House did not adopt Resolution 91-41.

RESOLUTION 91-31: Insurance for HIV-Positive Health Care Providers During the Period of Retraining

RESOLVED, That the Pennsylvania Medical Society study how insurance coverage could be made available to health care providers which would supplement the income of health care providers who are HIV positive during the period of retraining.

Mr. Speaker, your reference committee recommends that Resolution 91-31 be amended as follows:

RESOLVED, That the Pennsylvania Medical Society study [how] *what* insurance coverage [could be made] *is* available to *HIV-positive* health care providers which would supplement [the] *their* income [of health care providers who are HIV positive] during the period of retraining *and publicize the study results*.

Mr. Speaker, your reference committee recommends that Resolution 91-31 be adopted as amended.

Resolution 91-31 seeks to have the Pennsylvania Medical Society study how insurance coverage would be made available to HIV-positive health care providers which would supplement their income during the period of retraining.

Your reference committee heard testimony from the resolution's author indicating that several such insurance policies are already available. It would, therefore, be better for the Medical Society to publicize the availability of existing policies than to attempt to develop another approach to the problem.

It was moved and seconded from the floor of the House to refer Resolution 91-31 for further study. The House did not approve the motion by a vote of 133 to 78.

It was moved and seconded from the floor of the House to further amend Resolution 91-31 by deleting the words, "during the period of retraining" in the title and in the amended resolved. The House approved the motion. The House adopted as amended Resolution 91-31.

RESOLUTION 91-32: Retraining Courses for HIV-Positive Health Care Providers

RESOLVED, That the Pennsylvania Medical Society study how counseling and retraining programs should be made available to health care providers who are HIV positive and who perform invasive procedures; and be it further

RESOLVED, That the Pennsylvania Medical Society play a leadership role in developing retraining courses for HIV-positive health care providers.

Mr. Speaker, your reference committee recommends that the second resolve of Resolution 91-32 be amended as follows:

RESOLVED, That the Pennsylvania Medical Society play a leadership role in [developing] *the development of* retraining courses for HIV-positive health care providers.

Resolution 91-32 calls upon the Pennsylvania Medical Society to study how counseling and retraining programs should be made available for health care providers who are HIV positive and perform invasive procedures. It also calls for the Pennsylvania Medical Society to play a leadership role in developing retraining courses for HIV-positive health care providers.

Your reference committee believes it is a more appropriate role for the Pennsylvania Medical Society to provide leadership in developing retraining programs than to actually develop the training program itself.

The House adopted as amended Resolution 91-32.

RESOLUTION 91-25: AIDS Confidentiality of HIV-Related Information Act (ACT 148 OF 1990)

RESOLVED, That the Pennsylvania Medical Society seek revision of the AIDS-Confidentiality of HIV-Related Information Act (Act 148 of 1990) to *exclude physicians and their personnel from seeking other health care practitioners when significant exposure is encountered and allow these physicians to test themselves, their personnel, and their patients.*

Mr. Speaker, your reference committee recommends that Resolution 91-25 be amended as follows:

RESOLVED, That the Pennsylvania Medical Society seek revision of *that portion of* the AIDS-Confidentiality of HIV-Related Information Act (Act 148 of 1990) *which mandates* that physicians and their personnel seek other health care practitioners when significant exposure is encountered and *instead* allow these physicians to test themselves, their personnel, and their patients.

Mr. Speaker, your reference committee recommends that Resolution 91-25 be adopted as amended.

The author of Resolution 91-25 wishes to see the Pennsylvania Medical Society seek revision of the AIDS-Confidentiality of HIV-Related Information Act to allow physicians to certify their own and their employees' exposure to HIV as significant.

Your reference committee agrees with the intent of the resolution, but believes that these amendments make that intent much clearer.

It was moved and seconded from the floor of the House to further amend Resolution 91-25 by adding the words, "the consultation of" after the words, "which mandates that physicians and their personnel seek." The House approved the amendment. The House adopted as amended Resolution 91-25.

RESOLUTION 91-6: Student Exposure to HIV, Hepatitis B, and Other Infectious Agents

RESOLVED, That the Pennsylvania Medical Society investigate the education residents and students-in-training in Pennsylvania receive to limit their risk of exposure to HIV and Hepatitis B; investigate the status of policies at medical schools for students who may have been exposed to HIV and Hepatitis B during training; and develop a policy on these issues.

Mr. Speaker, your reference committee recommends that Resolution 91-6 be amended as follows:

RESOLVED, That the Pennsylvania Medical Society investigate the education residents and students-in-training in Pennsylvania receive [to limit their risk of exposure to HIV and Hepatitis B] *regarding infectious disease control policies and procedures, particularly universal precautions*; investigate the status of policies at medical schools for students who may have been exposed to HIV and Hepatitis B during training; [and develop a policy on these issues] *and encourage all medical schools without such a policy to develop one.*

Mr. Speaker, your reference committee recommends that Resolution 91-6 be adopted as amended.

Resolution 91-6 would have the Pennsylvania Medical Society investigate the education residents and students in Pennsylvania receive to limit their risk of exposure to HIV and Hepatitis B. It also calls for the Pennsylvania Medical Society to investigate the status of policies at medical schools for students who may have been exposed to HIV and Hepatitis B during training. The Pennsylvania Medical Society is then to develop a policy on these issues.

Your reference committee believes that students should be educated in preventing the transmission of all infectious diseases through proper use of universal precautions.

Your reference committee received testimony from the Pennsylvania Medical Society Medical School Section suggesting that the State Society not dictate that the medical schools adopt a particular training program, but assure that all medical schools have their own training programs. Your reference committee sees wisdom in that recommendation.

It was moved and seconded from the floor of the House to insert "/or" after the words, "investigate the status of policies at medical schools for students who have have been exposed to HIV and"; this was accepted as an editorial revision.

It was moved and seconded from the floor of the House to further amend Resolution 91-6 by replacing the words, "medical schools" with the words, "other medical educational institutions" so as to

read, "and encourage all other medical educational institutions without such a policy to develop one." The House approved the amendment. The House adopted as amended Resolution 91-6.

RESOLUTION 91-58: The Pennsylvania Clean Indoor Air Act

RESOLVED, That the Pennsylvania Medical Society recommend adoption of policies by the Commonwealth of Pennsylvania:

1. The need to eliminate smoking in public places and the need to include lobbies and hallways in this definition.
2. The need to eliminate smoking in businesses (including all workplaces) and the need to include factories and warehouses in this definition.
3. The need to allow localities (in addition to Allegheny County) to enact more stringent measures than the law which is applicable statewide.

; and be it further

RESOLVED, That the Pennsylvania Medical Society study whether the use of physical barriers between smoking areas and nonsmoking areas within restaurants should be mandated, taking into account the technology of air-exchange per unit time; and be it further

RESOLVED, That the Pennsylvania Medical Society study whether the penalties associated with violations of the law should be strengthened, and whether individuals should be permitted to report violations thereof.

Mr. Speaker, your reference committee recommends that Resolution 91-58 be amended by deletion of the second resolved.

Mr. Speaker, your reference committee recommends adoption of Resolution 91-58 as amended.

The purpose of Resolution 91-58 is to eliminate smoking in public places and businesses, and to allow local governments to enact more stringent measures than the current state law. It would also have the Pennsylvania Medical Society study whether physical barriers between smoking and non-smoking areas should be mandated. Finally, it would have the Pennsylvania Medical Society study whether the penalties for violation of the Clean Indoor Air Act should be strengthened and if individuals should be permitted to report violations of the law.

Your reference committee believes that the action called for by the second resolve is not practical. It would be prohibitively expensive for business owners to comply with such a mandate if the study indicates that it is necessary. It would not be feasible to call upon the business community to make such a large sacrifice at this time, nor would such legislation be likely to be enacted.

The House adopted as amended Resolution 91-58.

REPORT UU, BOARD OF TRUSTEES: Substance Abuse (RESOLUTION 90-65)

Mr. Speaker, your reference committee recommends that Board of Trustees Report UU be adopted.

This report is submitted by the Board in response to Resolution 90-65: Substance Abuse. It includes a comprehensive report on decriminalization of illicit drugs prepared by the Pennsylvania Medical Society Task Force on Drug Abuse.

Your reference committee heard nothing but positive testimony regarding this report. The reference committee wishes to commend the Pennsylvania Medical Society's Task Force on Drug Abuse for its hard work in creating this outstanding report.

The House adopted Board Report UU.

RESOLUTION 91-9: Pennsylvania Department of Health Fund a Facility to Treat Difficult Tuberculosis Cases

RESOLVED, That the Pennsylvania Medical Society urge the Pennsylvania Department of Health to identify and fund a facility where difficult-to-treat tuberculosis cases can be effectively treated to reduce the incidence of tuberculosis and to avoid the risk of spreading drug-resistant organisms.

Mr. Speaker, your reference committee recommends that Resolution 91-9 be amended as follows:

RESOLVED, That the Pennsylvania Medical Society urge the Pennsylvania Department of Health to identify and fund [a facility where] *appropriate mechanisms whereby* difficult-to-treat tuberculosis cases can be effectively treated to reduce the incidence of tuberculosis and to avoid the risk of spreading drug resistant organisms.

Mr. Speaker, your reference committee recommends that Resolution 91-9 be adopted as amended.

Resolution 91-9 would have the Pennsylvania Medical Society urge the Pennsylvania Department of Health to identify and fund a facility for treating difficult tuberculosis cases.

Your reference committee heard testimony suggesting that the critical issue involved in this resolution is providing adequate funding. Funding may be provided to existing facilities as appropriate so your reference committee did not wish to tie the Medical Society to the concept of supporting a new facility.

It was moved and seconded from the floor of the House to further amend Resolution 91-9 by inserting after the words, "RESOLVED, That the Pennsylvania Medical Society urge the Pennsylvania Department of Health to identify and" the words, "and the legislature to"; and to amend the title by changing the word, a, to the word, an, and deleting the word, facility, and replacing it with the words, appropriate mechanism, so as to read: Pennsylvania Department of Health Fund an Appropriate Mechanism to Treat Difficult Tuberculosis Cases. The House approved the amendments. The House adopted as amended Resolution 91-9.

Waiver of Debate List

The following items have been grouped together in a waiver of debate list; no testimony was heard, and the committee feels that the items are of a noncontroversial nature.

Mr. Speaker, your reference committee recommends that the following item be filed:

REPORT JJ, BOARD OF TRUSTEES: Task Force on Drug Abuse

The House approved filing the waiver of debate item.

Mr. Speaker, your reference committee recommends that the following items be adopted:

REPORT W, BOARD OF TRUSTEES: Tobacco-Related Legislation (RESOLUTION 90-13)

RESOLUTION 91-50: Pennsylvania Clean Indoor Air Act

RESOLVED, That the Pennsylvania Medical Society seek changes in appropriate Pennsylvania laws to include the following policies:

1. The need to eliminate smoking in public places and the need to include lobbies and hallways in this definition.
2. The need to eliminate smoking in businesses (including all work places) and the need to include factories and warehouses in this definition.
3. The need to allow all localities to enact more stringent measures than the law which is applicable statewide.

REPORT X, BOARD OF TRUSTEES: Tobacco Use (RESOLUTION 90-28)

RESOLUTION 91-37: Smoking Cessation

RESOLVED, That the Pennsylvania Medical Society urge all hospitals to have a mechanism(s) in place, be it pharmaceutical and/or other means, to facilitate the treatment of patients who desire help with smoking cessation; and be it further

RESOLVED, That the Pennsylvania Medical Society call upon the AMA to also urge all hospitals to have a mechanism(s) in place to facilitate the treatment of patients who desire help with smoking cessation.

REPORT DD, BOARD OF TRUSTEES: Substance Abuse Counselors and Substance Abuse Sobriety Houses (RESOLUTIONS 90-61 AND 90-62)

REPORT FF, BOARD OF TRUSTEES: Guidelines for Health Education in Pennsylvania

RESOLUTION 91-17: Access to Maternal and Child Health Care

RESOLVED, That the Pennsylvania Medical Society establish, as a public health priority, the issue of access to and delivery of maternal and child health care services; and be it further

RESOLVED, That the Society attempt to involve, in the furtherance of the priority of access to and delivery of maternal and child health care services, a broad spectrum of lay and professional organizations and agencies with demonstrated interest in the establishment of a comprehensive approach to delivery of quality maternal and child health care services in Pennsylvania.

RESOLUTION 91-23: Farm Injury Prevention for Low-Income Farmers

RESOLVED, That the Pennsylvania Medical Society ask the Commonwealth of Pennsylvania to consider implementation of a program offering to substantially subsidize the retrofitting of rollover protection and safety shielding of older farm equipment used by farmers having an annual income of less than 150 percent of the federal poverty level.

RESOLUTION 91-49: Pennsylvania Medical Society Position on Biomedical Research and Testing

RESOLVED, That the Pennsylvania Medical Society strongly endorse the policy of the American Medical Association which unequivocally supports the humane use of animals in biomedical research and teaching; and be it further

RESOLVED, That the use of animals in research and teaching must be carried out in compliance with current federal, state, local, and institutional laws and regulations; the development of suitable alternatives to the use of animals should be encouraged and supported by government and private organizations; and be it further

RESOLVED, That the Pennsylvania Medical Society support efforts by the American Medical Association and other medical societies to actively defend and promote such research, and to develop and present educational programs to inform physicians and the public of the benefits of the use of animals in research and teaching; and be it further

RESOLVED, That the Pennsylvania Medical Society support the current American Medical Association intent to organize national meetings to discuss the issue of research and the problems posed by animal rights activists; and be it further

RESOLVED, That the Pennsylvania Medical Society stress to the public its concern regarding the impact of animal rights activists and "animal liberation" groups on the conduct of biomedical research, and condemn all illegal activities which may be used by these groups; and be it further

RESOLVED, That the Pennsylvania Medical Society oppose many of the other tactics used by animal rights activists and "animal liberation" groups, including picketing, sit-ins, threats, and boycotts.

RECOMMENDATION 2d OF THE PRESIDENT-ELECT: Public Health Plan

The House adopted the waiver of debate items.

Reference Committee B

Presented by:
Abram M. Hostetter, MD

Mr. Speaker, members of the House of Delegates, Reference Committee B has considered all of the above items in the index.

RESOLUTION 91-28: Abortion

RESOLVED, That the Pennsylvania Medical Society inform the American College of Obstetrics and Gynecology and the American Board of Obstetrics and Gynecology of its opposition to the recommendations of the American College of Obstetrics and Gynecology regarding training and certification to perform abortions; and be it further

RESOLVED, That the Pennsylvania Delegation to the AMA present this same resolution for like action at the national level.

Mr. Speaker, your reference committee recommends that Resolution 91-28 be withdrawn at the request of the author.

The House approved the withdrawal of Resolution 91-28.

RESOLUTION 91-3: Abortion

RESOLVED, That the Pennsylvania Medical Society strongly urge the AMA to remain neutral on the issue of abortion, and that its officials cease any lobbying efforts to influence judicial or political opinion regarding the rendering of abortion services.

Mr. Speaker, your reference committee recommends that 91-3 not be adopted.

Resolution 91-3 urges the AMA to remain neutral on the issue of abortion and to refrain from lobbying efforts to influence judicial or political opinion on abortion. The intent of the resolution is to avoid alienating and disenfranchising those physicians that do not agree with either a pro or anti-abortion stance.

Considerable testimony was heard on both sides of the resolution. The author suggested amending the resolution to delete reference to lobbying efforts. However, further discussion did not resolve semantic and substantive differences regarding "neutral" versus "no position" policies.

RESOLUTION 91-45: Pennsylvania Medical Society Policy on Abortion

RESOLVED, That the Pennsylvania Medical Society recognizes the following three positions exist among its membership:

A. Those who believe that the pregnant women, when concurred with by her physician, herself shall determine that abortion is necessitated in her case; this is sometimes referred to as the "pro-choice" position.

B. Those who believe that fetal life has intrinsic individual value, but this can be overridden by specific grave medical risks and by specific socially undesirable conditions facing the mother and/or child.

C. Those who believe that the unborn child, from the moment of fertilization, has absolute intrinsic value to that of any child already born and equal to the mother herself. Sometimes called the "pro-life" ethic, this position places a responsibility on the physician to counsel and advise against induced abortion on demand, and to provide positive alternatives for women with socially undesirable pregnancies; and be it further

RESOLVED, That the Pennsylvania Medical Society not endorse a single position on abortion to the exclusion of the others; and be it further

RESOLVED, That the Pennsylvania Medical Society ask the AMA to adopt the aforementioned policies.

Mr. Speaker, your reference committee recommends that Resolution 91-45 not be adopted.

Resolution 91-45 calls for the Society to recognize that its members hold three distinct positions on the issue of abortion, to abstain from endorsing any one of these positions, and to ask the AMA to take a similar stance.

Again, this resolution generated considerable debate, and various proposals to amend were made by the authors. Your reference committee believes that this resolution is essentially identical with Resolution 91-3 and thus should not be adopted.

It was moved and seconded from the floor of the House to postpone temporarily Resolutions 91-3 and 91-45. The House approved postponing temporarily Resolutions 91-3 and 91-45.

RESOLUTION 91-4: Access to Health Care

RESOLVED, That the Pennsylvania Medical Society request the American Medical Association to develop a liaison task force with the Liaison Council on Medical Education to study the availability, distribution, and need for family physicians compared with the graduating statistics of medical schools with and without departments of family practice; and be it further

RESOLVED, That this task force report its results back to the Pennsylvania Medical Society House of Delegates.

RECOMMENDATION 2C OF THE PRESIDENT ELECT

Mr. Speaker, your reference committee recommends that Resolution 91-4 and Recommendation 2c be referred to the Board of Trustees for further study.

Resolution 91-4 requests the AMA, in collaboration with the Liaison Council on Medical Education, to conduct a comparative study of the need, distribution, and availability of family physicians versus graduation statistics for medical schools with and without family practice departments. The president elect's proposal calls on the Society to

strengthen efforts to reverse the "doctor drain" from rural and inner-city areas of the Commonwealth.

During testimony, it was indicated that several studies on this issue are currently in progress. Moreover, some witnesses suggested expanding the study parameters. There also appeared to be differences concerning limiting the scope to family practice as opposed to primary care. For these reasons, your reference committee believes further study is appropriate.

The House approved referring to the Board of Trustees for further study Resolution 91-4 and Recommendation 2c.

RESOLUTION 91-5: Resident Working Hours

RESOLVED, That the Pennsylvania Medical Society encourage residency programs to continually evaluate their individual programs with respect to appropriateness of resident working hours; and be it further

RESOLVED, That the Pennsylvania Medical Society discourage state legislation directed toward mandating specific regulations restricting resident working hours; and be it further

RESOLVED, That the Pennsylvania Medical Society address the issue of resident working hours with the AMA Accreditation Council on Graduate Medical Education.

Mr. Speaker, your reference committee recommends that Resolution 91-5 not be adopted.

Resolution 91-5 outlines a Society position that discourages legislative efforts to control working hours and encourages attention to the matter by residency programs and the AMA. The intent is to overcome a perception that resident working hours relate to the quality of health care and possible attempts to control such hours legislatively.

Testimony indicated that such a resolution is unnecessary since the Pennsylvania Medical Society already has a similar policy that adequately addresses the issue of resident working hours.

It was moved and seconded from the floor of the House to amend Resolution 91-5 with the insertion of the following additional resolved:

"RESOLVED, That the Pennsylvania Medical Society communicate directly to James Todd, MD, AMA executive vice president, its view that the following issue should be weighed when formulating a position regarding resident working hours: Limitations on resident working hours and on moonlighting are both subject to the relationship between the resident physician and the graduate medical education program director.

The House did not approve the amendment. The House did not adopt Resolution 91-5.

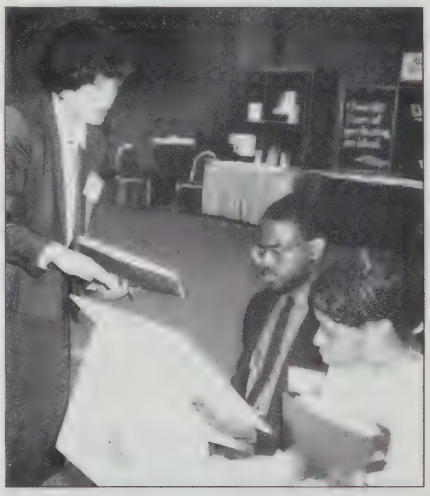
RESOLUTION 91-18: Physicians' Medical Records

RESOLVED, That the Pennsylvania Medical Society compile the existing guidelines regarding the disposition, storage, and dispersal of medical records belonging to retired/deceased physicians and report back at the next meeting; and be it further

RESOLVED, That the Pennsylvania Medical Society study the feasibility of maintaining a records retrieval data bank and storage system.

Mr. Speaker, your reference committee recommends that Resolution 91-18 be adopted.

Resolution 91-18 calls for the Society to compile existing guidelines regarding disposition, storage, and dispersal of medical records of a retired or deceased physician and to study the feasibility of the Society maintaining a storage and retrieval system for such records.



Shelley Urich, manager of administration and loans for the Society's Educational and Scientific Trust, discusses Trust programs with meeting attendees.

Your reference committee heard testimony that the Council on Medical Practice is preparing a comprehensive physician desk reference which will include a section on medical records and is investigating the feasibility of a storage and retrieval system. This resolution will serve to provide additional impetus to these efforts. It was also noted that a storage and retrieval system would have to protect patient confidentiality.

The House adopted Resolution 91-18.

RESOLUTION 91-22: Recognition of Osteopathic Medicine and Allopathic Medicine as Separate Entities within the Practice of Medicine

RESOLVED, That the Pennsylvania Medical Society acknowledge that the practice of osteopathic medicine is separate and distinct from the practice of allopathic medicine; and be it further

RESOLVED, That the Pennsylvania Medical Society intensify efforts to ensure a smooth working relationship with osteopathic physicians and their organizations so as to further the joint interests of both allopathic and osteopathic physicians.

Mr. Speaker, your reference committee recommends that Resolution 91-22 not be adopted.

Resolution 91-22 calls upon the Society to acknowledge the separateness and distinction between osteopathic and allopathic medicine while at the same time to ensure a smooth working relationship between the two to further their joint interests.

Your reference committee heard testimony on the history of unification efforts and their impact on the membership status of osteopathic physicians. We believe that Report D of the Board of Trustees being considered in Reference Committee F adequately addresses this issue and that this resolution would be in contradiction to that report.

The House did not adopt Resolution 91-22.

RESOLUTION 91-27: Adverse Experience Survey Regarding Dangerous Cults

RESOLVED, That the Pennsylvania Medical Society fund and participate in a confidential survey of physicians' experiences, both personal and professional, in cults.

RESOLUTION 91-29: Cults: A Medical Issue

RESOLVED, That the Pennsylvania Medical Society call upon the AMA to:

- Study the medical consequences of participation in cults;
- Inform America's physicians of the health risks associated with cult participation, including early identification of the symptoms and diagnosis of syndromes associated with cults, treatment options for cult victims, support services for the ex-cult member and his or her family, assessment of the potential practice of medicine in which these so-called "self help" groups engage; and
- Educate the American public, and particularly America's youth, about the dangers of participation in such groups.

Mr. Speaker, your reference committee recommends that Resolutions 91-27 and 91-29 be referred to the Board of Trustees for further study.

Resolution 91-27 calls for the Society to fund and conduct a confidential survey of physicians' experiences with cults. The intent is to develop a more quantitative estimate of the breadth and depth of the problem of cults. Resolution 91-29 calls on the Society to ask the AMA to: (1) study the medical consequences of participation in cults; (2) inform physicians of the associated health risks, to include diagnosis, treatment options, and support services; and (3) educate the American public about these dangers.

Testimony was overwhelmingly supportive of the intent of these resolutions. However, some witnesses

expressed legal and fiscal concerns in implementing them. Your reference committee believes, therefore, that further study is required.

The House approved referring Resolutions 91-27 and 91-29.

RESOLUTION 91-61: Provision for Student Health Insurance

RESOLVED, That the Pennsylvania Medical Society commission a study on health care coverage for all medical professionals-in-training in the Commonwealth of Pennsylvania (including medical students, nursing students, allied health care students, and residents); and be it further

RESOLVED, That the following issues be considered in that study:

1. The risks of occupationally acquired illness and resultant financial injury to medical, nursing, and allied health care students.

2. Student loan coverage of health insurance and health care costs.

3. Mechanisms for *providing* all medical professionals-in-training in the Commonwealth of Pennsylvania with adequate health care coverage at an affordable cost.

4. Mechanisms for *protecting* all medical professionals-in-training in the Commonwealth of Pennsylvania *and their dependents* from catastrophic financial loss resulting from an occupationally acquired illness or injury; and be it further

RESOLVED, That input from the Medical Student Section, Resident Physician Section, Medical School Section, and The Educational and Scientific Trust will be solicited in reference to this study.

Mr. Speaker, your reference committee recommends that Resolution 91-61 be adopted.

Resolution 91-61 requires the Society to conduct a study on the provision of health care coverage for all medical professionals-in-training. This study should consider occupational risks, student loans, mechanisms for affordable health coverage, and protective measures. Input is to be sought from the Medical Student Section, Resident Physician Section, Medical School Section, and The Educational and Scientific Trust.

Testimony was highly supportive of the intent to provide cost effective health insurance to medical professionals-in-training. However, there was not consensus on how this insurance could be funded.

The House adopted Resolution 91-61.

RESOLUTION 91-62: Sexual Harassment

RESOLVED, That the Pennsylvania Medical Society adopt the AMA guidelines as their own policy on sexual harassment; and be it further

RESOLVED, That the Pennsylvania Medical Society endorse and enact future AMA measures which decrease the prevalence of sexual harassment in all areas of the medical profession, and not only medical training; and be it further

RESOLVED, That the Pennsylvania Medical Society adopt the AMA guidelines or similar guidelines on their own.

Mr. Speaker, your reference committee recommends that Resolution 91-62 be referred to the Board of Trustees for further study.

Resolution 91-62 calls on the Society to adopt either the AMA guidelines on sexual harassment or similar ones of our own. Your reference committee heard testimony from the Medical Student Section to clarify the resolution. Nonetheless, without access to the AMA guidelines themselves, your reference committee was hesitant to take a position on this most important issue.

The House approved referring Resolution 91-62.

RESOLUTION 91-64: Confidentiality Rights of Pharmaceutical Companies

RESOLVED, That the Pennsylvania Medical Society consider an investigation into the practicalities and adverse medical consequences of pharmaceutical confidentiality rights; and be it further

RESOLVED, That the Pennsylvania Medical Society report their findings back to the Pennsylvania Medical Society Medical Student Section.

Mr. Speaker, your reference committee recommends that Resolution 91-64 not be adopted.

Resolution 91-64 asks the Society to consider investigating the practicalities and adverse medical consequences of pharmaceutical confidentiality rights and report its findings to the Medical Student Section. This resolution stems from recent publicity concerning the Upjohn Company and its sleep medication, Halcion.

The reference committee believes that the resolution is based on media reports and that the Medical Society has no means to determine the validity of such claims. Moreover, it was believed that existing federal agencies, such as the FDA, already have the mandate and the resources to investigate such matters.

The House did not adopt Resolution 91-64.

REPORT Y, BOARD OF TRUSTEES: Right to Die Legislation (RESOLUTION 90-20)

Mr. Speaker, your reference committee recommends that Board of Trustees Report Y be referred to the Board of Trustees for further study.

Report Y recommends that the Society not adopt Resolution 90-20 which advocates the concept of a court-appointed health care representative for patients who become incompetent to make their own health care decisions and who have not designated a surrogate. The report expresses great reservations about this concept because of the increased likelihood of judicial involvement in the physician-patient relationship.

Testimony heard by your reference committee suggested that the requirements of the Patient Self-Determination Act which will be implemented on December 1, 1991, will impact on this report. Accordingly, your reference committee believes that further study is required.

The House approved referring Board Report Y.

REPORT EE, BOARD OF TRUSTEES: Dispensing of Medication (RESOLUTION 90-66)

Mr. Speaker, your reference committee recommends that Board of Trustees Report EE be referred to the Board of Trustees for further study.

Report EE reaffirms the right of physicians to dispense medications from their offices and supports adoption of the AMA Ethical Principles on Dispensing of Medication as the appropriate guidelines for such physicians.

Several witnesses questioned the impact of the recently promulgated Safe Harbor regulations. As it was unclear what effect these regulations would have on physician dispensing, the report should be referred.

The House approved referring Board Report EE.

REPORT BBB, BOARD OF TRUSTEES: Expert Witness Policy for all Salaried and Volunteer Staff Physicians

Mr. Speaker, your reference committee recommends that Board of Trustees Report BBB be referred to the Board of Trustees for further study.

Report BBB establishes general principles for medical school faculty members to participate as expert witnesses and for the monitoring responsibilities of their respective departments. The resolution solicits possible action by the House of Delegates.

This report generated considerable discussion for and against. Several conflicting points of view emerged which will require further study to resolve.

The House approved referring Board Report BBB.

Waiver of debate list

The following have been grouped together in a waiver of debate list. No testimony was heard and the committee feels that these items are of a noncontroversial nature.

Mr. Speaker, your reference committee recommends that the following item be filed:

REPORT A, COUNCIL ON EDUCATION AND SCIENCE

The House approved filing the waiver of debate item.

Mr. Speaker, your reference committee recommends that the following item be

referred to the Board of Trustees for further study:

RESOLUTION 91-20: Expert Testimony and Independent Medical Reports

RESOLVED, That the Pennsylvania Medical Society use its resources to encourage the Pennsylvania State Board of Medicine to adopt a stated policy to scrutinize the provision of forensic medical services by its licensees in the same manner in which the Board scrutinizes the provision of expert medical care by those licensees.

It was moved and seconded from the floor of the House to adopt Resolution 91-20. The House adopted Resolution 91-20.

Mr. Speaker, your reference committee recommends that the following items be adopted:

RESOLUTION 91-30: Organ Donation

RESOLVED, That the Pennsylvania Medical Society work with The Hospital Association of Pennsylvania to insure that no hospital in Pennsylvania charges donor families for organs that are donated; and be it further

RESOLVED, That the Pennsylvania Medical Society work with The Hospital Association of Pennsylvania to insure that patients and the public are informed that there will be no charge for organ donations.

REPORT E, BOARD OF TRUSTEES: Support of Medical Schools (RESOLUTION 90-83)

REPORT S, BOARD OF TRUSTEES: Prioritization of Health Care Resources (RESOLUTION 90-58 and 1990 REPORT O, BOARD OF TRUSTEES)

REPORT V, BOARD OF TRUSTEES: REVISION OF STATE DEATH Certificates (RESOLUTION 90-1)

REPORT Z, BOARD OF TRUSTEES: Physician Involvement with Euthanasia (RESOLUTION 90-21)

REPORT AA, BOARD OF TRUSTEES: State Funds for Adult Day Care Centers (RESOLUTION 90-75)

REPORT BB, BOARD OF TRUSTEES: Discrimination Against International Medical Graduates (RESOLUTION 90-47)

REPORT PP, BOARD OF TRUSTEES: Policy Review (1990 REPORT L, BOARD OF TRUSTEES)

It was moved and seconded from the floor of the House to extract Board Report S from the waiver of debate list. The House approved the motion. It was moved and seconded from the floor of the House to amend Board Report S by deleting the first sentence in the fourth paragraph which states, "The Council continues its efforts to establish priorities." and inserting in its place the sentence, "The Pennsylvania Medical Society will study the establishment of priorities for medical care in Pennsylvania and report back to the House after the study is completed."

It was moved and seconded from the floor of the House to refer back to the Board Report S. The House approved referring Board Report S.

The House adopted the remainder of the waiver of debate items.

Mr. Speaker, your reference committee recommends that the following item not be adopted:

RESOLUTION 91-57: The Impact of the Iraq-Kuwait Conflict on the American Soldier

RESOLVED, That the Pennsylvania Medical Society ask the AMA to provide information and educational materials to the public and to the profession regarding the psychological impact of participation in all wars including the Iraq-Kuwait War.

The House did not adopt Resolution 91-57.

It was moved and seconded from the floor of the House to resume consideration of Resolutions 91-3 and 91-45. The House did not approve the motion.

Annual Assessment

John W. Lawrence, MD, chairman of the Finance Committee of the Board of Trustees, presented the following report containing the recommendation of the Finance Committee that the annual assessment for dues-paying members for 1992 remain at $430.

Mr. Speaker and members of the House of Delegates, at the first session of this House, I presented a report on the 1992 budget which included a recommendation of no dues increase. In that report, I stated that the actions of this House could have an effect on the 1992 budget. House actions have not resulted in a significant change in the budget from that presented Friday.

Consequently, the Board of Trustees recommends that the regular dues for 1992 be $430 for each full dues-paying member and a proportionate share thereof in other dues-paying categories.

Further, the House has approved a recommendation from the Board of Trustees setting student dues at $5 and a report from the Board recommending that $10 from the 1992 annual assessment be allocated to the Education Fund of The Educational and Scientific Trust.

It was moved and seconded from the floor of the House to approve the recommendation of the Finance Committee that the 1992 annual assessment be $430 per active member. The House approved the motion.

Dr. Rhoads recognized Kay A. Barrett, Director of House Operations, who reported that there was no new business before the House.

The House of Delegates adjourned at 11:15 a.m.

Respectfully submitted,
Jonathan E. Rhoads Jr., MD, Speaker
Howard A. Richter, MD, Vice Speaker
Ferdinand L. Soisson Jr., MD, Secretary
Kay A. Barrett, Director of House Operations and Policy Maintenance
Arnold W. Cushner, Vice President for General Administration

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91-1 (Reference Committee D), Subject: Scope of Psychological Practice in the Hospital Setting; Introduced by: James R. Regan, MD, chairman, on behalf of the Interspecialty Section, and Diehl M. Snyder, MD, delegate, on behalf of the Psychiatric Physicians of Pennsylvania; Author: Lawrence L. Altaker, MD, president, on behalf of the Psychiatric Physicians of Pennsylvania

91-2 (Reference Committee E), Subject: Practice Parameters; Introduced by: James J. Houser, MD, secretary, Venango County Medical Society; Author: James J. Houser, MD

91-3 (Reference Committee B), Subject: Abortion; Introduced by: William R. Beltz, MD, secretary, Lycoming County Medical Society; Author: James W. Redka, MD, Lycoming County Medical Society

91-4 (Reference Committee B), Subject: Access to Health Care; Introduced by: Robert J. Fagioletti, MD, on behalf of the Pennsylvania Academy of Family Physicians; Author: Pennsylvania Academy of Family Physicians Board of Directors

91-5 (Reference Committee B), Subject: Resident Working Hours; Introduced by: Robert J. Fagioletti, MD, on behalf of the Pennsylvania Academy of Family Physicians; Author: Pennsylvania Academy of Family Physicians Board of Directors

91-6 (Reference Committee G), Subject: Student Exposure to HIV, Hepatitis B, and Other Infectious Agents; Introduced by: Robert J. Fagioletti, MD, on behalf of the Pennsylvania Academy of Family Physicians; Author: Pennsylvania Academy of Family Physicians Board of Directors

91-7 (Rules Committee), Subject: "Bullet Balloting"; Introduced by: Leland F. Patterson, MD, on behalf of the Dauphin County Medical Society; Author: Dauphin County Medical Society

91-8 (Reference Committee G), Subject: Honoring the American Lung Association of Pennsylvania; Introduced by: Richard T. Bell, MD, Pennsylvania Society for Pulmonary Disease; Author: Richard T. Bell, MD

91-9 (Reference Committee G), Subject: Pennsylvania Department of Health Fund a Facility to Treat Difficult Tuberculosis Cases; Introduced by: Richard T. Bell, MD, Pennsylvania Society for Pulmonary Disease; Author: Richard T. Bell, MD

91-10 (Reference Committee F), Subject: Dues Exemption for Fully Retired Physicians; Introduced by: George E. Connerton, MD, secretary, Berks County Medical Society; Author: Mark S. Reed, MD, Berks County Medical Society

91-11 (Reference Committee G), Subject: HIV Testing of Providers; Introduced by: James L. Harrison, MD, on behalf of the Lycoming County Medical Society; Author: James P. Speichinger, MD, Lycoming County Medical Society

91-12 (Reference Committee F), Subject: Membership Requirements; Introduced by: Norman A. Goldstein, MD, Chester County Medical Society; Author: Lucy E. Hornstein, MD, Chester County Medical Society

91-13 (Reference Committee E), Subject: Efforts to Improve Care and Control Costs; Introduced by: Robert J. Carroll, MD, Allegheny County Medical Society; Author: Robert J. Carroll, MD

91-14 (Reference Committee E), Subject: Geriatrics as Valid Medical Specialty for Medicare; Introduced by: Richard P. Kennedy, MD, secretary, Monroe County Medical Society; Author: Marc S. Berger, MD, Monroe County Medical Society

91-15 (Reference Committee G), Subject: Mandatory HIV Testing; Introduced by: Robert J. Fagioletti, MD, Pennsylvania Academy of Family Physicians; Author: Robert J. Fagioletti, MD

91-16 (Reference Committee E), Subject: Medicaid Reform in House Bill 20; Introduced by: Ernest M. Wood, MD, Lancaster City and County Medical Society; Author: Robert G. Doe, MD, Lancaster City and County Medical Society

91-17 (Reference Committee G), Subject: Access to Maternal and Child Health Care; Introduced by: Peter A. Schwartz, MD, on behalf of the Pennsylvania Section of the American College of Obstetricians and Gynecologists, and F. Dennis Dawgert, MD, on behalf of the Pennsylvania Chapter of the American Academy of Pediatrics; Author: Peter A. Schwartz, MD

91-18 (Reference Committee B), Subject: Physicians' Medical Records; Introduced by: J. Walter Valenteen, MD, Delaware County Medical Society; Author: Delaware County Medical Society Board of Directors

91-19 (Reference Committee D), Subject: Tort Reform; Introduced by: James A.

Morris Jr., MD, Delaware County Medical Society; Author: Delaware County Medical Society Board of Directors

91-20 (Reference Committee B), Subject: Expert Testimony and Independent Medical Reports; Introduced by: David L. Cohen, MD, on behalf of the York County Medical Society, and Charles A. Heisterkamp III, MD, on behalf of the Lancaster City and County Medical Society; Author: David L. Cohen, MD

91-21 (Reference Committee E), Subject: Medical Assistance Participation; Introduced by: James J. Houser, MD, Venango County Medical Society; Author: James J. Houser, MD

91-22 (Reference Committee B), Subject: Recognition of Osteopathic Medicine and Allopathic Medicine as Separate Entities within the Practice of Medicine; Introduced by: John A. Malcolm Jr. MD, Secretary, Union County Medical Society; Author: John A. Malcolm Jr., MD

91-23 (Reference Committee G), Subject: Farm Machine Injury Prevention for Low-Income Farmers; Introduced by: John A. Malcolm Jr. MD, Secretary, Union County Medical Society; Author: Union County Medical Society

91-24 (Reference Committee D), Subject: Pennsylvania Medical Society's Legislative Lobbying Organization; Introduced by Samuel G. Woodings, MD, Mercer County Medical Society; Author: Joseph A. Giordano, MD, Mercer County Medical Society

91-25 (Reference Committee G), Subject: AIDS-Confidentiality of HIV-Related Information Act (Act 148 of 1990); Introduced by: Samuel G. Woodings, MD, Mercer County Medical Society; Author: Joseph A. Giordano, MD, Mercer County Medical Society

91-26 (Reference Committee F), Subject: Honoring a Pennsylvania Medical Society Physician Member for Community Volunteer Service; Introduced by: Barton L. Smith, MD, president, Berks County Medical Society; Author: Richard T. Bell, MD, Berks County Medical Society

91-27 (Reference Committee B), Subject: Adverse Experience Survey Regarding Dangerous Cults; Introduced by: Edward A. Lottick, MD, on behalf of the Luzerne County Medical Society; Author: Edward A. Lottick, MD

91-28 (Reference Committee B), Subject: Abortion; Introduced by: Timothy M. Heilmann, MD, secretary, Lawrence County Medical Society; Authors: Timothy M. Heilman, MD, and Anthony S. Mastrian, MD, Lawrence County Medical Society

91-29 (Reference Committee B), Subject: Cults: A Medical Issue; Introduced by: Andre C. Blanzaco, MD, secretary, on behalf of the Board of Directors of the Philadelphia County Medical Society; Author: Barbara A. Shelton, MD, Philadelphia County Medical Society

91-30 (Reference Committee B), Subject: Organ Donation; Introduced by: Andre C. Blanzaco, MD, secretary, on behalf of the Board of Directors of the Philadelphia County Medical Society; Author: Andre C. Blanzaco, MD

91-31 (Reference Committee G), Subject: Insurance for HIV-Positive Health Care Providers During the Period of Retraining; Introduced by: Andre C. Blanzaco, MD, secretary, on behalf of the Board of Directors of the Philadelphia County Medical Society; Author: Donald Kaye, MD, Philadelphia County Medical Society



Mrs. Gary Strebel, president of the AMA Auxiliary, was one of several guests who spoke during the 1991 House session.

91-32 (Reference Committee G), Subject: Retraining Courses for HIV-Positive Health Care Providers; Introduced by: Andre C. Blanzaco, MD, secretary, on behalf of the Board of Directors of the Philadelphia County Medical Society; Author: Donald Kaye, MD, Philadelphia County Medical Society

91-33 (Reference Committee E), Subject: Automatic Processing of Major Medical Claims; Introduced by: Andre C. Blanzaco, MD, secretary, on behalf of the Board of Directors of the Philadelphia County Medical Society; Author: Donald Kaye, MD, Philadelphia County Medical Society

91-34 (Reference Committee F), Subject: Dues Freeze and Prioritization of Society Activities; Introduced by: Andre C. Blanzaco, MD, secretary, on behalf of the Board of Directors of the Philadelphia County Medical Society; Author: Richard M. Gash, MD, Philadelphia County Medical Society

91-35 (Reference Committee F), Subject: Effective Mechanism for Installment Payment of Dues; Introduced by: Andre C. Blanzaco, MD, secretary, on behalf of the Board of Directors of the Philadelphia County Medical Society; Author: Richard M. Gash, MD, Philadelphia County Medical Society

91-36 (Reference Committee F), Subject: Timely Consideration of Actions Affecting Pennsylvania Medical Society Dues; Introduced by: Andre C. Blanzaco, MD, secretary, on behalf of the Board of Directors of the Philadelphia County Medical Society; Author: Timothy J. Michals, MD, Philadelphia County Medical Society

91-37 (Reference Committee G), Subject: Smoking Cessation; Introduced by: Andre C. Blanzaco, MD, secretary, on behalf of the Board of Directors of the Philadelphia County Medical Society; Authors: David J. Shulkin, MD, and Robert B. Sklaroff, MD, Philadelphia County Medical Society

91-38 (Reference Committee G), Subject: AIDS/HIV Testing; Introduced by: James L. Harrison, MD, FACS, on behalf of the Lycoming County Medical Society, and John H. Moyer, MD, DSc, Pennsylvania Society of Internal Medicine; Author: James L. Harrison, MD, FACS, and John H. Moyer, MD, DSc

91-39 (Reference Committee C), Subject: Small Area Analysis; Introduced by: Robert B. Sklaroff, MD, Philadelphia County Medical Society; Authors: Robert B. Sklaroff, MD, David M. Sklaroff, MD, and Rachmel Cherner, MD, Philadelphia County Medical Society

91-40 (Rules Committee), Subject: Pennsylvania Medical Society "Bullet Ballot"; Introduced by: Robert B. Sklaroff, MD, Philadelphia County Medical Society; Authors: Robert B. Sklaroff, MD, David M. Sklaroff, MD, and Rachmel Cherner, MD, Philadelphia County Medical Society

91-41 (Reference Committee G), Subject: Physicians with AIDS; Introduced by: Gilbert A. Friday Jr., MD, Allegheny County Medical Society; Author: Gilbert A. Friday Jr., MD

91-42 (Reference Committee G), Subject: HIV Testing; Introduced by: Gilbert A. Friday Jr., MD, Allegheny County Medical Society; Author: Gilbert A. Friday Jr., MD

91-43 (Reference Committee C), Subject: Publication in *Federal Register* of Proposed Changes in PRO Review Process or Procedures; Introduced by: Robert D. Reinecke, MD, Pennsylvania Academy of

Ophthalmology; Author: Robert D. Reinecke, MD

91-44 (Reference Committee E), Subject: Explanation of Payments by Health Insurers; Introduced by: James C. Barton, MD, Franklin County Medical Society; Author: Calvin B. Early, MD, Franklin County Medical Society

91-45 (Reference Committee B), Subject: Pennsylvania Medical Society Policy on Abortion; Introduced by: Robert Sklaroff, MD, Philadelphia County Medical Society; Authors: John D. Lane, MD, Bucks County Medical Society, and Louis Gerstley III, MD, Philadelphia County Medical Society

91-46 (Reference Committee C), Subject: Pennsylvania State Health Department Reviews; Introduced by: Stanley M. Marks, MD, president, Allegheny County Medical Society; Author: Stanley M. Marks, MD (Withdrawn)

91-47 (Reference Committee D), Subject: Transfer of Funds from the Federal Defense Budget to Health Care Needs; Introduced by: William A. Freeman, MD, Franklin County Medical Society; Author: William A. Freeman, MD

91-48 (Reference Committee E), Subject: Deletion of CPT Code; Introduced by: Lawrence K. Harris, MD, FACC, on behalf of the Pennsylvania Chapter, American College of Cardiology; Author: Lawrence K. Harris, MD, FACC (Withdrawn)

91-49 (Reference Committee G), Subject: Pennsylvania Medical Society Position on Biomedical Research and Testing; Introduced by: Robert B. Buckingham, MD, Allegheny County Medical Society; Author: Robert B. Buckingham, MD

91-50 (Reference Committee G), Subject: Pennsylvania Clean Indoor Air Act; Introduced by: Edward H. Dench Jr., MD, on behalf of the Pennsylvania Medical Society Hospital Medical Staff Section; Authors: James H. Dovnarsky, MD and Robert B. Sklaroff, MD, Pennsylvania Medical Society Hospital Medical Staff Section

91-51 (Reference Committee E), Subject: Proposed Elimination of Professional Component Reimbursement for EKG Interpretation; Introduced by: Edward H. Dench Jr., MD, on behalf of the Pennsylvania Medical Society Hospital Medical Staff Section; Author: Michael Daniels, MD, Pennsylvania Medical Society Hospital Medical Staff Section

91-52 (Reference Committee C), Subject: Proper Notification of a Physician Regarding Possible Loss of Medical Staff Membership or Privileges; Introduced by: Edward H. Dench Jr., MD, on behalf of the Pennsylvania Medical Society Hospital Medical Staff Section; Author: Erwin A. Cohen, MD, Pennsylvania Medical Society Hospital Medical Staff Section

91-53 (Reference Committee C), Subject: Appropriate Appeals Procedure Following Recommendation by the Medical Executive Committee Regarding Loss of Medical Staff Membership or Privileges; Introduced by: Edward H. Dench Jr., MD, on behalf of the Pennsylvania Medical Society Hospital Medical Staff Section; Author: Erwin A. Cohen, MD, Pennsylvania Medical Society Hospital Medical Staff Section

91-54 (Reference Committee C), Subject: Study of Medical Staff Experiences with the National Practitioner Data Bank; Introduced by: Edward H. Dench Jr., MD, on behalf of the Pennsylvania Medical Society Hospital Medical Staff Section; Author: Erwin A. Cohen, MD, Pennsylvania Medical Society Hospital Medical Staff Section

91-55 (Reference Committee F), Subject: Conflict of Interest; Introduced by: Carl A. Frankel, MD, on behalf of the Pennsylvania Medical Society Young Physicians Section; Author: Robert B. Sklaroff, MD, Pennsylvania Medical Society Young Physicians Section

91-56 (Reference Committee F), Subject: Recognition of "Specialty" Boarded-Status; Introduced by: Carl A. Frankel, MD, on behalf of the Pennsylvania Medical Society Young Physicians Section; Author: Robert B. Sklaroff, MD, Pennsylvania Medical Society Young Physicians Section

91-57 (Reference Committee B), Subject: The Impact of the Iraq-Kuwait Conflict on the American Soldier; Introduced by: Carl A. Frankel, MD, on behalf of the Pennsylvania Medical Society Young Physicians Section; Author: Robert B. Sklaroff, MD, Pennsylvania Medical Society Young Physicians Section

91-58 (Reference Committee G), Subject: The Pennsylvania Clean Indoor Air Act; Introduced by: Carl A. Frankel, MD, on behalf of the Pennsylvania Medical Society Young Physicians Section; Author: Robert B. Sklaroff, MD, Pennsylvania Medical Society Young Physicians Section

91-59 (Reference Committee F), Subject: Number of Pennsylvania Medical Society Young Physicians Section Delegates to the Pennsylvania Medical Society House of Delegates; Introduced by: Carl A. Frankel, MD, on behalf of the Pennsylvania Medical Society Young Physicians Section; Author: Robert B. Sklaroff, MD, Pennsylvania Medical Society Young Physicians Section

91-60 (Reference Committee F), Subject: Fiscal Note; Introduced by: Carl A. Frankel, MD, on behalf of the Pennsylvania Medical Society Young Physicians Section; Author: Robert B. Sklaroff, MD, Pennsylvania Medical Society Young Physicians Section

91-61 (Reference Committee B), Subject: Provision for Student Health Insurance; Introduced by: Belinda Enders, on behalf of the Pennsylvania Medical Society Medical Student Section; Author: Pennsylvania Medical Society Medical Student Section

91-62 (Reference Committee B), Subject: Sexual Harassment; Introduced by: Belinda Enders, on behalf of the Pennsylvania Medical Society Medical Student Section; Author: Pennsylvania Medical Society Medical Student Section

91-63 (Reference Committee G), Subject: The Compliance of Pennsylvania Physicians to CDC Guidelines on HIV Control; Introduced by: Belinda Enders, on behalf of the Pennsylvania Medical Society Medical Student Section; Author: Pennsylvania Medical Society Medical Student Section

91-64 (Reference Committee B), Subject: Confidentiality Rights of Pharmaceutical Companies; Introduced by: Belinda Enders, on behalf of the Pennsylvania Medical Society Medical Student Section; Author: Pennsylvania Medical Society Medical Student Section

91-65 (Reference Committee F), Subject: National Scholarship Fund; Introduced by: Belinda Enders, on behalf of the Pennsylvania Medical Society Medical Student Section; Author: Pennsylvania Medical Society Medical Student Section

Special Committee on AMA Delegation Matters (Reference Committee F)

Special House Committee to Study Combining the Office of Chairman and President (Reference Committee F)

Standing Committee Reports

Advisory Committee on Professionalism (Reference Committee F)

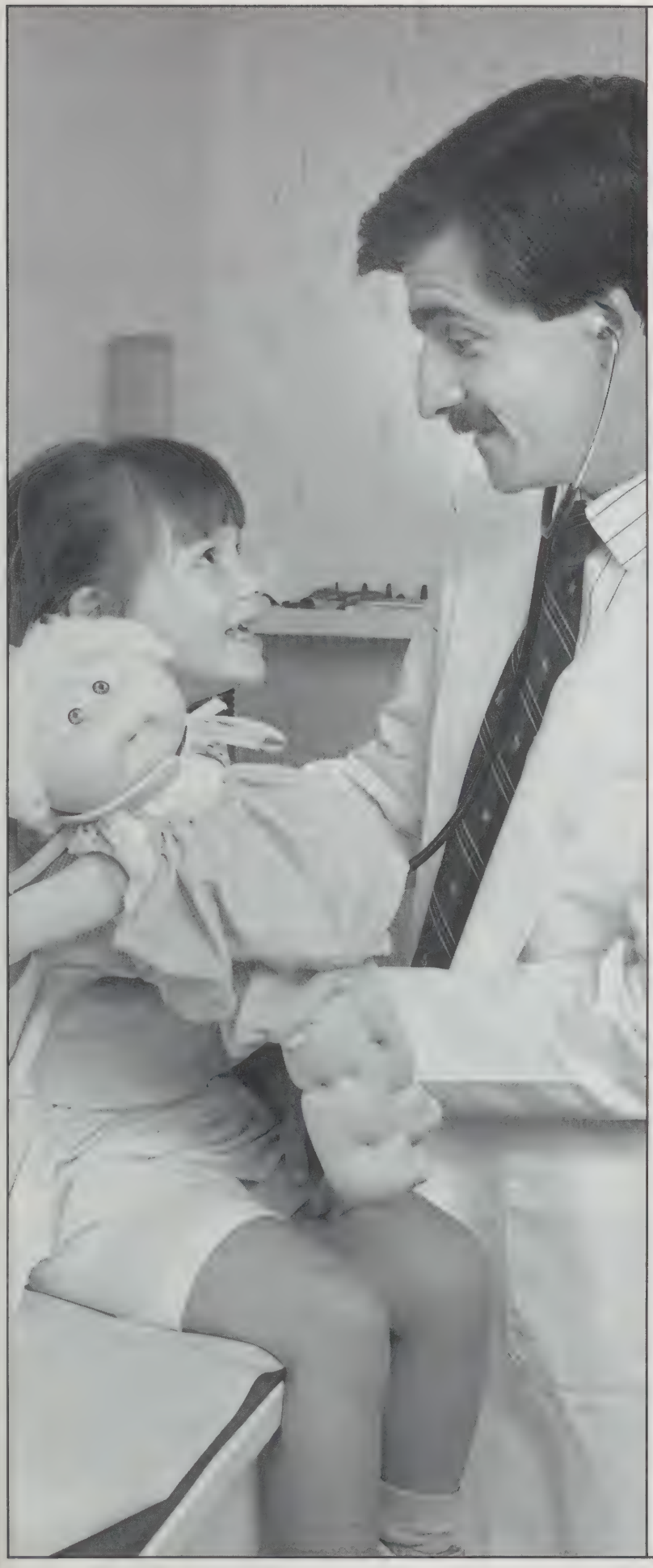
Aid to Education (Reference Committee F)

Committee on Bylaws (Reference Committee A)

Medical Benevolence (Reference Committee F)

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Young Physicians Section Report (Reference Committee F)



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Update: Medicare Patient Records in Physicians' Offices

Donald E. Harrop, MD

We have become aware of a growing concern among physicians who are under the impression that review of Medicare patients' records in physicians' offices is imminent. Our current activity of reviewing care provided by health maintenance organizations (HMOs) may have caused some physicians to believe that such review had already started. HMO review may, at times, include a request for office records, but such requests are made to the HMO. The review does *not* take place at the physician's office.

Although the law mandates that private office review commence on January 1, 1992, the Health Care Financing Administration (HCFA) has not yet drafted a methodology or proposed regulations for such review. Presently, there are three pilot projects in progress in other states which focus on office review; these involve voluntary participation by local physicians and use widely varying approaches. The aim of such projects is to define in a descriptive way what is actually happening in physicians' offices, and how the quality and cost effectiveness of care delivered in the ambulatory setting may be monitored.

Because of the January 1 mandates and the "possibility" that HCFA may require the start of office review within the foreseeable future, the American Medical Peer Review Association (AMPRA), in conjunction with a number of specialty societies, has proposed guidelines for documentation of ambulatory encounters. (See "Guidelines..." on page 59.) The intent in developing the guidelines is to encourage additional dialogue and to provide some advance instructions on medical record documentation so that when review of office records becomes a reality, physicians will be better prepared.

Regardless of what type of review is eventually implemented and how cases are selected for review, the basis will be the medical record, just as it is for inpatient hospital cases. The guidelines will permit physicians to assess their current documentation practices and give some thought as to what changes or improvements are appropriate. Physicians and others who currently manage ambulatory quality assurance programs may find the guidelines similarly useful. We are hopeful that re-examining current practices and making changes, when necessary, will result in a less eventful introduction of office record review.

This is not to say that office review is necessarily near; it's hard to tell how long it will be before it becomes a reality. My personal opinion is that it is probably years away. I say this for several reasons. First, just because a law has been enacted does not mean that a program to implement it will immediately be developed and put into place. For example, PRO denials for substandard care were mandated by the 1985 Consolidated Omnibus Budget Reconciliation Act (COBRA). Draft regulations were not published in the *Federal Register* until January 1989 and elicited an unusually large number of comments from the public and the medical and provider communities. This appeared to cause HCFA to rethink their implementation approach. Final regulations, which were originally due for publication in August 1991, are now scheduled for March 1992. We will see.

Developing an office-based review program which will be fair, will not be disruptive to a physician's practice, and will be cost effective, is an extremely difficult task. HCFA recently discontinued preadmission/preprocedure review of 10 selected procedures because the program could not meet those criteria. I would not expect them to make a similar mistake and, therefore, do not think there will be review in physicians' offices until there is a thoroughly considered, tested, and acceptable plan of how the review will be accomplished. That will take time.

Donald E. Harrop, MD, is president of the Keystone Peer Review Organization.

Guidelines for Documentation of Ambulatory Encounters

Operational philosophy

A patient's health record should include sufficient information:

1. to assess the previous treatment,
2. to ensure continuity of care, and
3. to ensure necessary and appropriate testing and/or therapy.

Guidelines for documentation for ambulatory encounters

1. The medical record should be clearly legible and reviewable.

2. The documentation of a patient encounter should include clinical history, clinical findings, assessment, and plan for care.

3. The plan of care should, when appropriate, include medication types, frequency, dosage, specific instructions for follow-up, informed consent, and education indicating patient participation.

4. The documentation should support that the intensity of the patient evaluation and treatment reflected the reason for the encounter, the intensity of the problem, and the findings of the examination.

5. It is suggested that the date and time of day of each encounter be documented.

6. Patient non-compliance, such as failure to return for an appointment, should be documented.

7. Significant x-rays, lab tests, and other ancillary study results should be addressed.

8. The reason for x-rays, lab tests, and other ancillary studies should be documented in the medical record.

9. The originator of the medical record entry should be identifiable.

10. If the physician assumes management of a patient in another locale, that management should be documented in the appropriate medical record.

11. Relevant risk factors should be identified.

12. When appropriate, past and present diagnoses should be accessible to the consulting/treating physician.

13. Patient referrals and consultations should be documented.

Referral: Care transferred to another physician who assumes management of the care which precipitated the referral.

Consultation: The primary physician retains responsibility for the patient.

14. The documentation in the record should support the CPT/ICD codes billed.

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E. Albert Reece, MD, the Abraham Roth professor and chairperson of the Department of Obstetrics, Gynecology, and Reproductive Services at Temple University School of Medicine, has been named national chairperson for the OB/GYN section of the National Medical Association.

Leon S. Malmud, MD, vice president of Temple University's Health Sciences Center, recently attended the European Society of Nuclear Medicine meeting in Vienna, Austria. At the meeting he chaired a plenary session on gastrointestinal nuclear medicine. Dr. Malmud also recently participated in a leadership meeting in Phoenix, Arizona, of all specialty groups representing nuclear medicine, as well as the American College of Nuclear Physicians meeting in Washington, DC.

At its fifth annual Physicians' Tribute Dinner, Albert Einstein Healthcare Foundation recently honored three physicians for their clinical excellence and compassion for patients. They are **Bernard Zamostein, MD,** and **Hallam Hurt, MD,** of Albert Einstein Medical Center; and **Michael Zal, DO,** of Philadelphia Psychiatric Center.

Frederick R. Heckler, MD, was elected president of the American Association for Hand Surgery. Dr. Heckler is director of the Division of Plastic Surgery at Allegheny General Hospital.

Jane Summers, MD, has been named director of Pennsylvania Hospital's Postpartum Disorders Project. Dr. Summers is an associate psychiatrist at The Institute of Pennsylvania Hospital and liaison to the hospital's Department of Obstetrics and Gynecology.

Dana C. Mears, MD, has been named to the board of trustees at D.T. Watson Rehabilitation Hospital. Dr. Mears is chief of the Division of Orthopedic Surgery at Shadyside Hospital.

Dennis J. Hurwitz, MD, has been elected president of the Ohio Valley Society of Plastic and Reconstructive Surgery.

Alan S. Berger, MD, clinical senior instructor of otolaryngology at Hahnemann University, recently served as chairman and presenter at two sinusitis seminars sponsored by Hahnemann. His associate, **William Henry, MD,** also presented.

George F. Murphy, MD, has been named the Herman Beerman Professor of Dermatology at the University of Pennsylvania.

Henry D. Unger, MD, has been appointed assistant professor of surgery and director of the Division of Emergency Medicine of Hahnemann University.

Albert J. Finestone, MD, associate dean emeritus of continuing medical education and professor and geriatrics coordinator at Temple University School of Medicine, was named director of Temple's Institute on Aging.

Teresa A. Nolan, MD, internal medicine specialist, received a three-year appointment as cancer liaison physician for the cancer program at Forbes Health System.

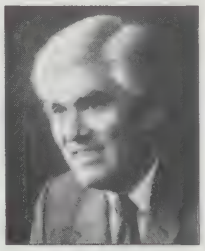
Harold J. Isard, MD, chairman emeritus of the Radiological Department at Albert Einstein Medical Center, received the Pennsylvania Radiological Society's prestigious Gold Medallion Award. Dr. Isard was recognized for his major contribution to the advancement of mammography and other breast imaging techniques in the battle against breast cancer.



Renowned neurologist and author Oliver Sacks, MD, whose book *Awakenings* received wide acclaim as a motion picture, recently discussed mental illness and its impact on family life at Albert Einstein Medical Center during the Annual Freda Kraftsow Sacks/Albert Einstein Society Lecture, commemorating Mental Health Awareness Week. Pictured (L-R) are: Paul Fink, MD, chairman of Einstein's Department of Psychiatry and medical director of the Philadelphia Psychiatric Center; Freda Kraftsow Sacks; and Oliver Sacks, MD.



Dr. H. Ostrum



Dr. B. Ostrum

Bernard J. Ostrum, MD, Nazareth Hospital radiologist, received the 1991 Philadelphia Roentgen Ray Society Award in recognition of his outstanding teaching skills and his pioneering work in and service to the field of radiology. His father, **Herman W. Ostrum, MD,** received the same award in 1966.

The American Academy of Family Physicians established a memorial lecture in memory of **Mark A. Connelly, MD,** a Lancaster physician killed in February 1990 by a land mine in Iraq. The lecture will be offered annually to focus on the human side of family medicine, the "art of family medicine," or the role of the family in the family physician's personal life.

Peter R. Laibson, MD, director of the cornea service at Wills Eye Hospital, received the Castroviejo Medal for his outstanding work in the field of corneal diseases and surgery.



Dr. Laibson

Robert E. Campbell, MD, chairman of the Department of Radiology at Pennsylvania Hospital, was awarded honorary membership in the European Congress of Radiology and Association of Radiologists.

Cyril H. Wecht, MD, JD, was appointed adjunct professor in the Department of Physician Assistants at the Graduate School of Health Sciences at Duquesne University.

Robert J. Sclabassi, MD, professor of neurosurgery at the University of Pittsburgh, received the Distinguished Alumni Award for Professional Achievement from Loyola Marymount University.

Gary Ferguson, MD, a Pittsburgh orthopedic surgeon, participated in a

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Soviet/American exchange in November. During time in Lithuania, Dr. Ferguson worked with a group of surgeons who studied at the Latvian Scientific Research Institute of Orthopedics and Traumatology, which jointly coordinated the program with the Keggi Orthopedic Foundation.

Gerald Andriole, MD, past president of the Pennsylvania Medical Society, participated in a panel discussion at a meeting of the Wyoming Valley Association of Life Underwriters. The discussion focused on "Solutions to the Health Care Crisis."



Dr. Andriole

Christopher J. Daly, MD, Pittsburgh, was visiting professor of surgery at the British Hospital in Buenos Aires, Argentina, in 1991. He also was visiting professor of surgery at the University of Kuala Lumpar, Malaysia.

Bruce L. Wilder, MD, JD, a Pittsburgh neurosurgeon, presented "Informed Consent," the first of a series of medical malpractice seminars cosponsored by the Allegheny County Medical Society. Other speakers participating included: **John A. Burkholder, MD; James D. O'Toole, MD; Daniel R. Sullivan, MD, JD;** and **Anne L. Wedemeyer, MD, JD.**



Harvey Silberman, MD (L), physician at Albert Einstein Medical Center, and Alfred Meltzer, vice president and general director of the Philadelphia Psychiatric Center, orgranized a one-month fellowship for Eva Janelovics, MD, one of five staff physicians at the Jewish Hospital and Home of Budapest, Hungary. Albert Einstein Medical Center "adopted" the 250-bed hospital and brought Dr. Janelovics to Philadelphia to learn modern medical techniques.

Gregory C. Moran, MD, of Geisinger Medical Center, was elected as one of two resident delegates to the 1992 American Academy of Family Physicians Congress of Delegates.

Irwin Becker, MD; Harry Frankel, MD; Paul McCausland, MD; and **Barry Cooper, MD,** were named as top family physicians in *Philadelphia* magazine's September 1991 issue. The four were the most frequently named by their physician colleagues as quality practitioners in their chosen specialties.

Donald W. Marion, MD, chief of the head injury service at Presyterian University Hospital, is the principal investigator for a University of Pittsburgh Medical Center project to develop a comprehensive head injury research center. The Medical Center received a grant of more than $1 million for the project.

Michael F. Gleeson, MD, was named director of the Department of Surgery at Carbondale General Hospital.

Francis J. Duggan Jr., MD, urologist with the Central Pennsylvania Urologic Association, was re-elected chairman of the Capital Area Health Foundation board of directors.

Abraham J. Twerski, MD, psychiatrist at Gateway Rehabilitation Center, served as keynote speaker for a Pittsburgh Theological Seminary workshop entitled, "The Role of Clergy in Chemical Dependency Treatment." Dr. Twerski also served as keynoter at the D.T. Watson Rehabilitation Hospital's Second Annual Jonus Salk Lecture.

Ivo P. Janecka, MD, associate professor of otolaryngology at the University of Pittsburgh School of Medicine, received the American Academy of Otolaryngology's Honor Award in recognition of his professional and academic activities.

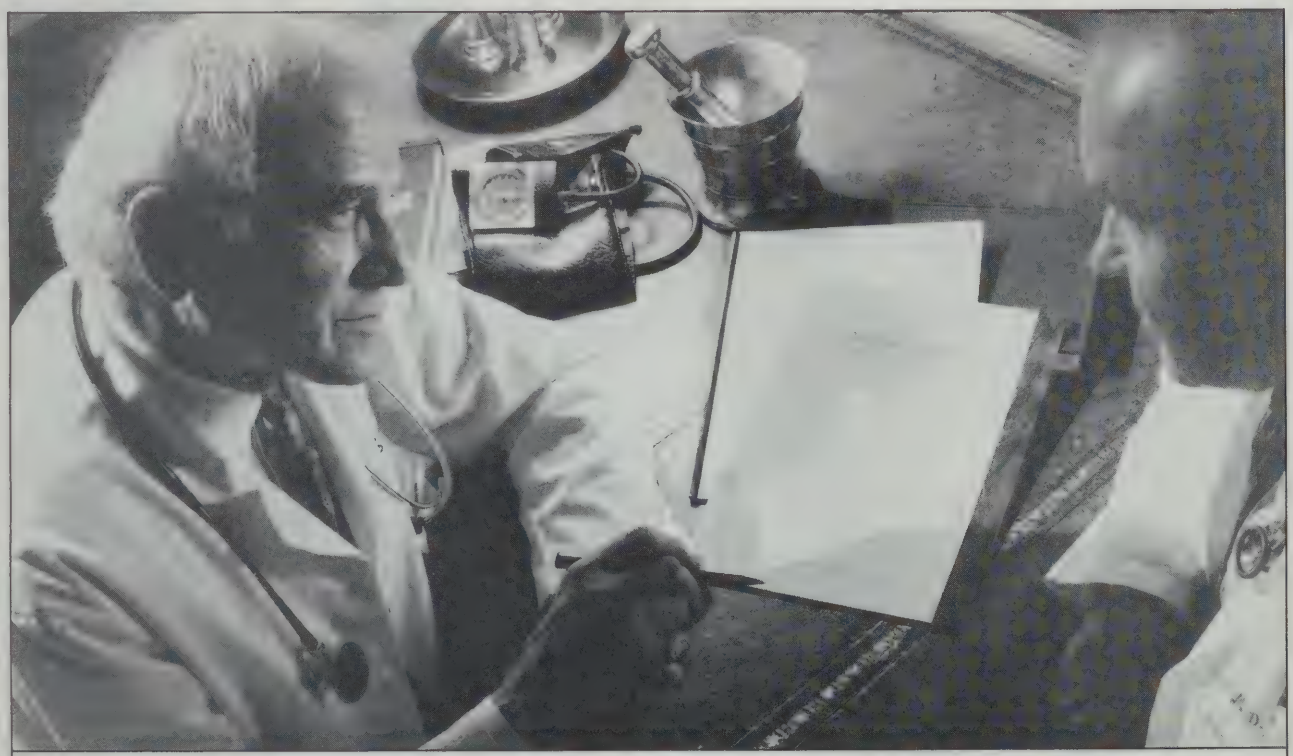
A. Linn Weigel, MD, general surgeon, was elected to a fourth term as president of the Emergency Medical Service Institute in Pittsburgh and was also elected to serve on the Institute's Board of Directors. **Richard S. Evans, MD,** will serve as alternate director-at-large.

David William Kennedy, MD, professor and chairman of the Department of Otorhinolaryngology: Head and Neck Surgery at the University of Pennsylvania Medical Center, has become president-elect of the American Rhinologic Society.

Mary Ann Peberdy, MD, Oreland, was appointed director of the coronary care unit of the Medical College of Pennsylvania.



Harry J. Buncke, MD (far right), director of the Department of Microsurgical Replantation and Transplantation at Davies Medical Center in San Francisco, and clinical professor of the Division of Plastic Surgery at the University of California Medical School, discussed "The Development of Microsurgery" as visiting professor in hand surgery for the 15th Annual Dorothy B. Kaufmann Lectureship, sponsored by Jefferson Medical College and the Hand Rehabilitation Foundation. Pictured with Dr. Buncke are (L-R): Lawrence H. Schneider, MD, director of the Division of Hand Surgery and Rehabilitation, Orthopedic Surgery at Jefferson; Evelyn J. Mackin, PT, Foundation executive director; James M. Hunter, MD, distinguished professor of orthopedic surgery, and president of the Hand Rehabilitation Center and the Foundation; and Mrs. Dorothy B. Kaufmann.



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Advanced Trauma Life Support Provider Course (ATLS)
Friday & Saturday,January 10 & 11, 1992 or
Friday & Saturday, March 13 & 14, 1992

Advances in Dermatology
Wednesday, April 1, 1992

Advanced Cardiac Life Support Renewal Course
Saturday, April 4, 1992

Update in Family Practice
Wednesday, April 8, 1992
Danville Days Inn

2nd Annual Focus on Sports Medicine
Saturday, April 11, 1992
Danville Days Inn

Controversies in the Management of Prostate Diseases
Wednesday, April 15, 1992

Pediatric Advanced Life Support Provider Course
Thursday, Friday, April 23 & 24, 1992

Airway Diseases
Wednesday, April 29, 1992

6th Annual Sight Loss Support Group Meeting
Wednesday, May 6, 1992
Danville Days Inn

Pediatric Advanced Life Support Provider Course
Thursday, Friday, May 7 & 8, 1992

Care of the Diabetic with the Dysvascular Foot
Wednesday, May 13, 1992

Update in Obstetrics & Gynecology
Wednesday, May 20, 1992
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AIR FORCE

How To Organize For Legislative Effectiveness

John E. Devenney, MD

Organization directly impacts the effectiveness of any legislative effort, and grassroots leadership is the key to organization. The following article originated as a message from the president to the members of the Montgomery County Medical Society (MCMS). Recognizing the broader implications of the letter, MCMS Executive Director U. Berkley Ellis submitted Dr. Devenney's article to be excerpted in PENNSYLVANIA MEDICINE.

A very highly respected physician was once quoted as saying, "Pick an area and focus all your energy on its development. Then you will have something worthwhile." Because every problem facing physicians and patients today has its origin in a rule, regulation, or law, we need to focus on legislation.

It is my goal to develop an integrated grassroots physician network not only in Montgomery County, but also in the surrounding Second Councilor District of Bucks, Berks, Delaware, Chester, and Lehigh counties.

I intend to build on the present Legislative Action Teams and the Federal Key Contacts in a number of different ways. Instead of depending only on moral suasion and rational argument, as in the past, I want to take it to the next level of influence: *money and votes*.

Money in the political arena equates to fundraising. Several of us have begun to develop this idea locally. Dr. Roberta Schneider and myself have had a successful fundraiser in Montgomery County in which more than 50 physicians participated in support of a friend of medicine. Delaware County was a major influence in getting in excess of 60 physicians to contribute to a fundraiser for a local Pennsylvania legislator. These prototype efforts have not gone unnoticed. Comments such as, "those are very impressive, surprising efforts," and "it looks like physicians are finally getting serious," are being heard in Harrisburg frequently.

The point is that we are getting their attention and I don't intend to lose this momentum. We want to expand and build upon these initial efforts. The goal is to get a nucleus of physicians for each senator and representative in our district. This group, approximately 10 in number, will commit themselves to financial backing of a specific legislator in their area and will then become the "go to" group for that legislator.

Equally important to legislators are *votes*. An individual physician vote doesn't amount to much, but a bloc of Second Councilor District, as well as individual county physician votes, will be enough to sway elections. In conjunction with the State Society, we embarked on a major voter registration effort. If we can get all targeted county societies' memberships registered, it would equate to approximately 5,000 votes (theoretically 10,000-15,000 if spouse and eligible offspring were included). That's a lot of votes!

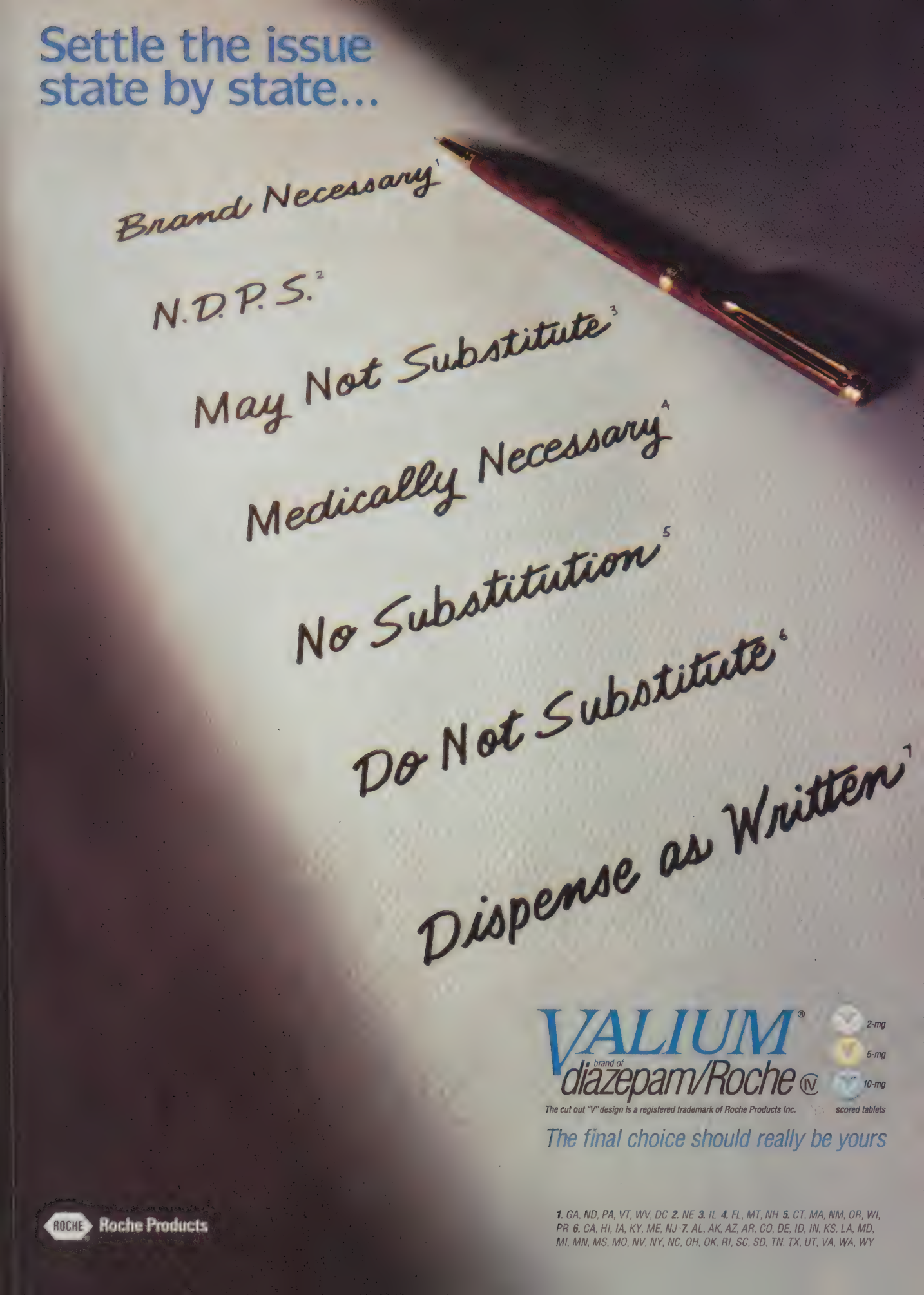
To turn that body of votes into a unified bloc, we will obtain and disseminate the legislators' voting records on health care to these registered voters.

It is important that the legislators know that we have this large bloc of votes and that these voters be kept regularly informed of the voting history of legislators on health care issues. We intend to communicate this.

It is my opinion that if we can achieve these two goals and add them to the existing Legislative Action Teams and the Federal Key Contact Program, we will go a long way toward becoming "serious players in the legislative arena." I will do everything I can to get us there.

Dr. Devenney is president of the Montgomery County Medical Society and chair of its Political Action Committee. He also serves as chair of the Federal Key Contact Program and a member of the State Society's Council on Government Relations.

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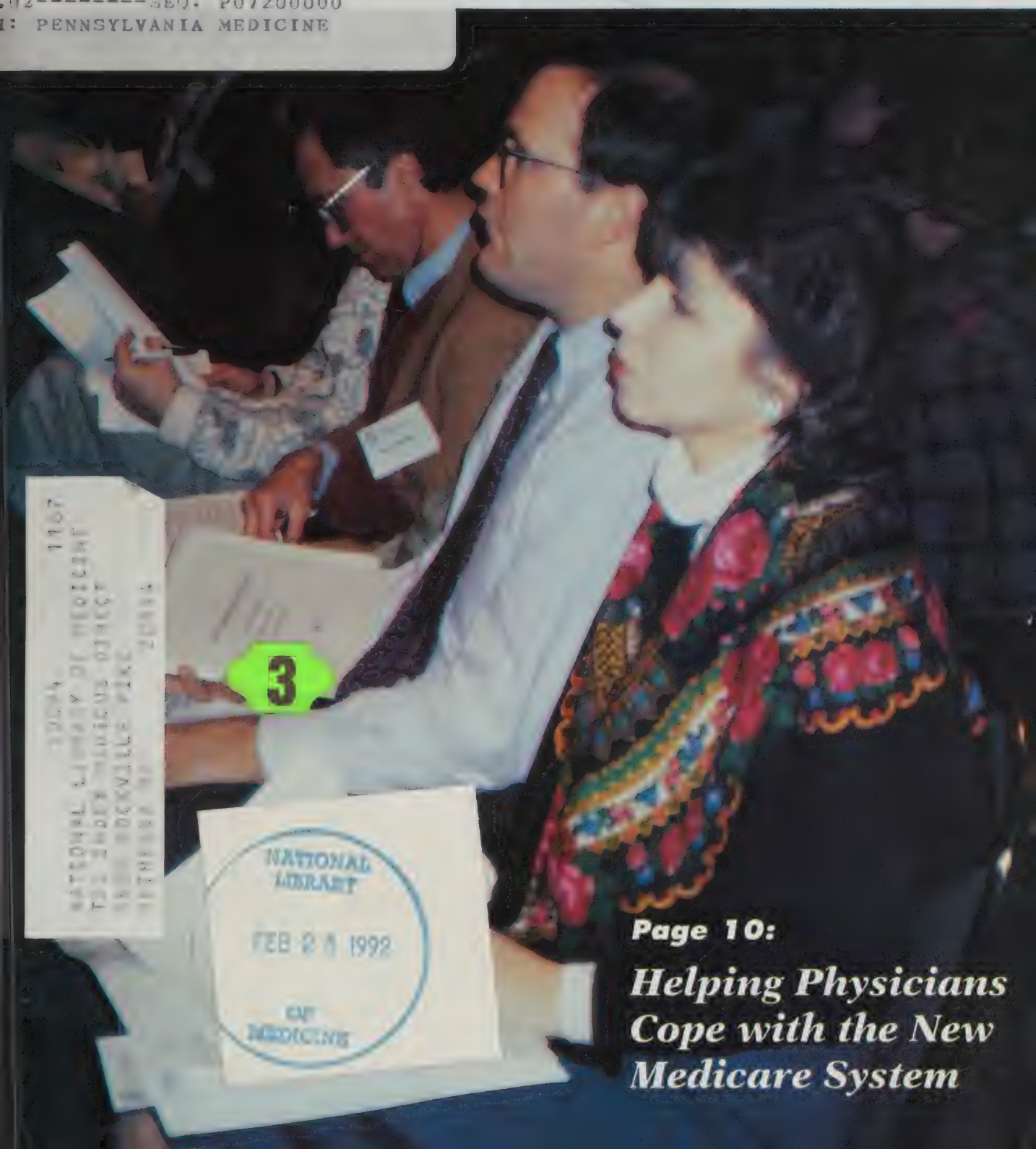
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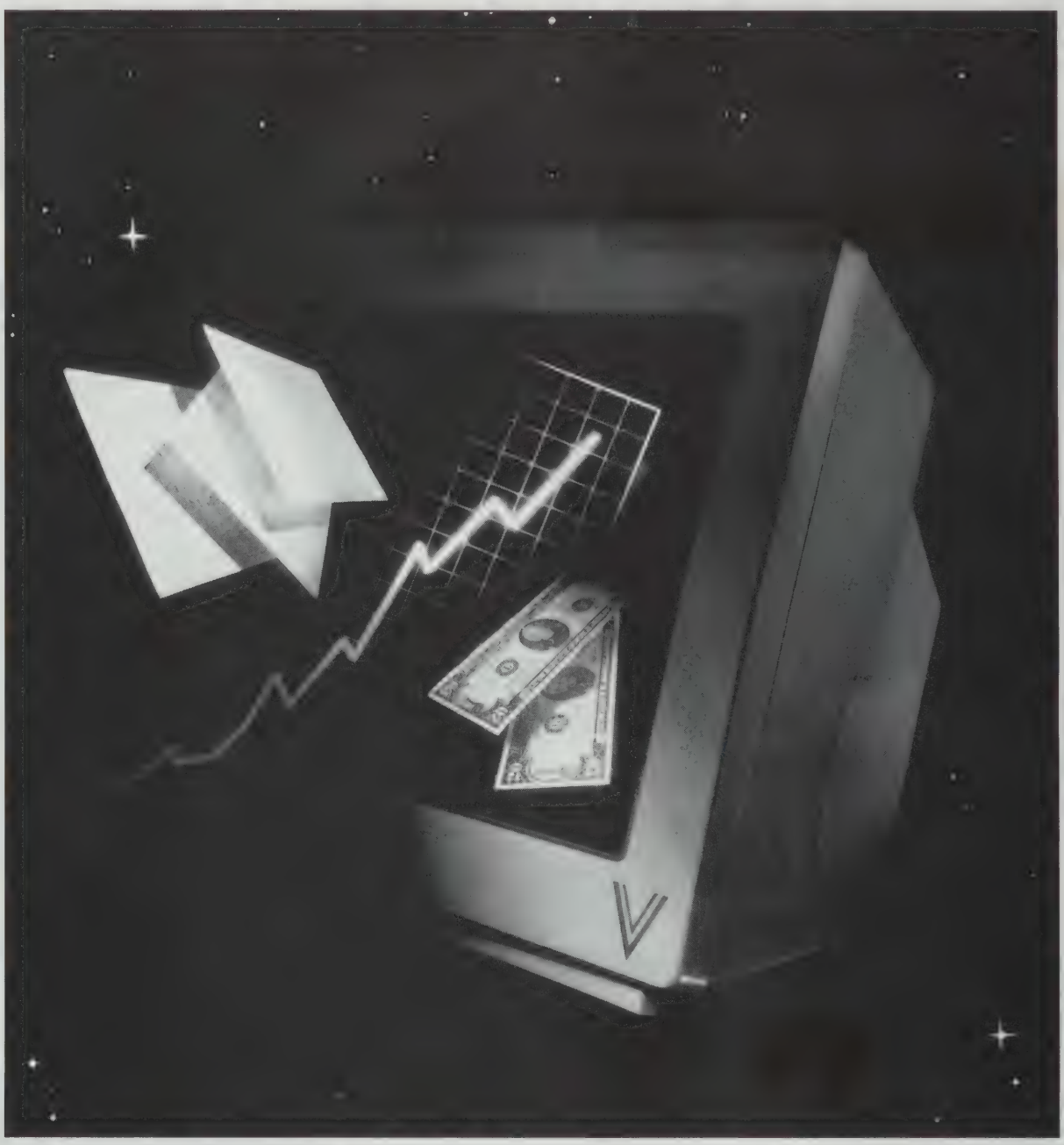
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Helping Physicians Cope with the New Medicare System

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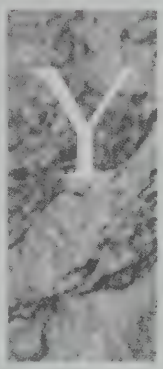
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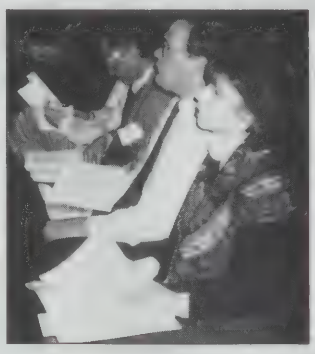
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Though physicians are not responsible for calculation of complex resource based relative value scale (RBRVS) fee schedule amounts, they need to understand and work within the new Medicare payment system. The Society offers this overview to help them do just that.



Cover photo by John Wright: Physicians attending a Society-sponsored meeting in Allentown to inform them about Medicare payment system changes.

32 *Diverse Leaders Strive for Common Goal*



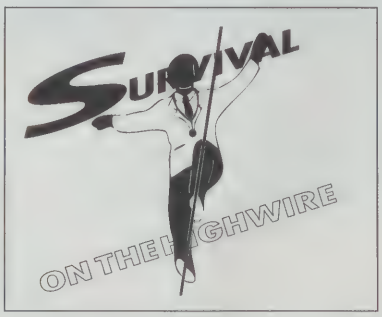




Over the course of the next three issues of PENNSYLVANIA MEDICINE, readers will meet the Society's newly elected trustees and learn their interests and views on practice, politics, and organized medicine.

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A nationally known leader of organized medicine will be the featured speaker at the Society's annual conference, which will focus on issues that can cause physicians to "wobble" on the highwire of medical practice in today's financial and social climate.



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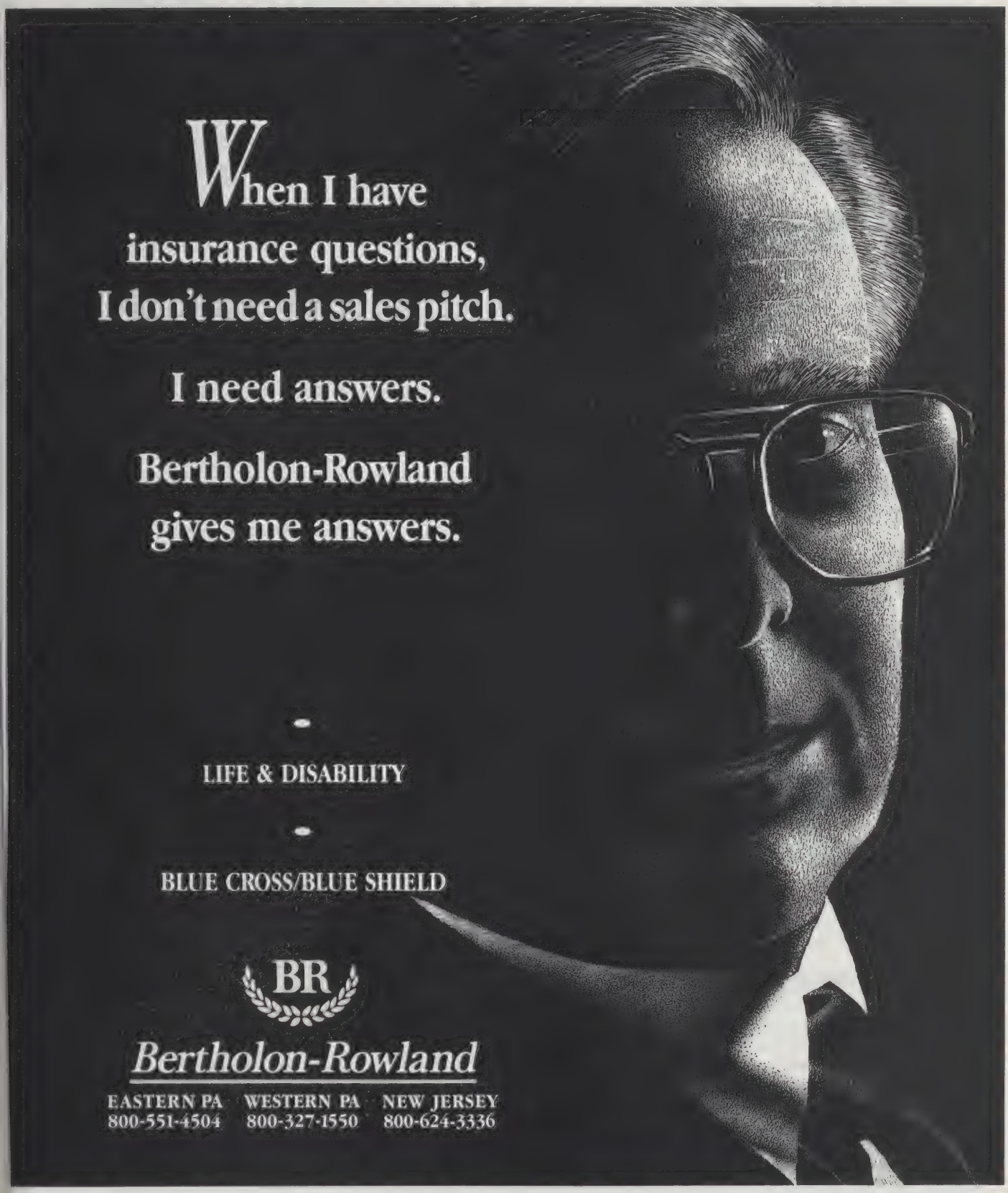
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PENNSYLVANIA MEDICINE (ISSN 0031-4595) is published monthly by the Pennsylvania Medical Society, 777 East Park Drive, Harrisburg, PA 17111.
SUBSCRIPTIONS: $20 per year— United States and Canada; $30—all others. Single issues $3.00 per copy prepaid; special issues cost more.
POSTMASTER: Send address changes to PENNSYLVANIA MEDICINE, 777 East Park Drive, PO Box 8820, Harrisburg, PA 17105–8820. Second class postage paid at Harrisburg, PA 17105.


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HCFA EXTENDS E/M CODE GRACE PERIOD: The Health Care Financing Administration (HCFA) has granted physicians an extension of the evaluation and management (E/M) code grace period. Previously, the grace period only applied to services rendered on or before January 31, 1992. The grace period has been extended an additional month: *physicians may use the old E/M codes for services rendered on or before February 29, 1992.* As previously, a claim must be made at 1991 reimbursement levels if an old code is used. The AMA is still attempting to secure an extension of the grace period to three months.

CARRIERS TO REJECT MEDICARE SUPERBILLS: Effective May 1, Medicare carriers will no longer accept claim attachments in lieu of information that should have been included in the designated blocks of the HCFA 1500 claim form. Preprinted forms (i.e., superbills) used by some physicians will no longer be accepted. Incomplete claim forms will be returned to the billing individual for proper completion and resubmission. Carriers will accept claim attachments only for information and evidence that cannot be entered in designated blocks (i.e., medical records to justify medical necessity).

SOCIETY CONTINUES TO OPPOSE WORKERS' COMPENSATION LINK TO MEDICARE: The State Society has taken several steps to warn against linking the state workers' compensation system to the federal Medicare system. During a January 28 news conference in Harrisburg, Society President Robert N. Moyers, MD, called upon the Senate to reject the Medicare tie and consider an alternative developed by the Society in cooperation with the Hospital Association of Pennsylvania. Several other organizations—including the Pennsylvania Osteopathic Medical Association and those representing orthopedics, psychology, podiatry, chiropractics, orthotics, and prosthetics—supported the Society. A series of letters to the editor, a display in the Senate side of the rotunda, and a 60-second radio spot were also developed by the Society to address the issue. At publication, legislative action is imminent.

SOCIETY TO HOST HEALTH FORUM: The State Society will convene a forum on the health effects of hazardous waste incineration early next month in Harrisburg. Participants are to include physician leaders, members of the Society's Commission on Public Health, and state and national experts. Though the State Society maintains a neutral position on such incineration, the idea for the forum was prompted by physician concern about the proposal to locate a hazardous industrial waste incinerator in Union County. Currently, the state Department of Environmental Resources is holding public hearings on that case, and a decision on whether to issue a site permit is due by March 12. For additional information about the forum, call 1-800-228-7823.

LEADERSHIP CONFERENCE DEADLINES SET: The following registration deadlines have been set for "Survival on the High Wire," the State Society's annual Leadership Conference to be held April 14-15, 1992, at the Hershey Lodge and Convention Center: hotel registration deadline—March 13, 1992; conference registration deadline—March 20, 1992. For additional information, see page 40 or call 1-800-228-7823.

BLUES UNVEIL "SPECIAL CARE" PROGRAM: In January, Blue Cross/Blue Shield unveiled a newly proposed insurance program, "Special Care," which would provide medical benefits and services to the under- and uninsured in Pennsylvania. The specifics of the program are currently under review by the State Society to determine if Special Care objectives are consistent with Society policy.

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"Physician, Heal Thyself": In the '90s and Beyond

John W. Mills, MD
Medical Editor

It seems incongruous to me that the Health Care Financing Administration (HCFA) picked the holiday season to begin the new Medicare payment system for health care providers—physicians being the largest targeted group. While illness and medical emergencies continue unabated throughout the year, we physicians generally look to the holiday season as a time when there will be less demand for our services so we can, with the rest of the nation, spend some precious time with family and friends and reflect on our traditions.

"We must assimilate the stressors so we are not only survivors, but examples of successful survivors."

OBRA '89 mandated the new RBRVS system. HCFA, in working out the details, underestimated the medical profession's reaction to some "slight-of-hand" calculations when they published the proposed rules in June 1991. The avalanche of comments from physicians, led by organized medicine, stunned HCFA and made Congress realize that HCFA had misinterpreted their mandate and overstepped their bounds with some assumptions and calculations.

This unprecedented reaction caused a delay in the smooth transition to resource based relative value scale (RBRVS) system expected by HCFA. So, while the holiday season should have been a time for physicians to relax with family and friends, it was instead filled with frustration, doubt, fear, and uncertainty. Our professional lives have always been stressful; now we must add this new "stressor" to an already overstimulated professional being.

So that we won't suddenly light up the "TILT" in our central nervous system, I suggest that each physician consider an integrated program to help manage the increasing stress. Make a concentrated effort to abide by the following resolutions, which will have a far greater effect on your well-being than the usual, half-hearted, joking New Year's resolutions:

- Use seatbelts at all times, behind the wheel and as a passenger.
- Stop tobacco usage.
- Be extremely careful with alcohol usage.
- Pay more attention to your diet—the essential ingredient: keeping fat content below 25 percent of total calorie intake.
- Avoid all substance abuse; and if you are having trouble, call the Society's Physicians Health Programs at 1-800-228-7823 and get help STAT!
- Attempt three 40- to 60-minute periods a week of brisk walking—if possible, outdoors.
- Find daily time (two 15-minute periods) to "reflect."
- Spend some worship time weekly—whatever your faith.
- Try to keep your pace a bit slower/steadier, rather than spiked with spurts.
- Drive defensively—stop trying to beat the other guy.
- Do unto others as you would have them do unto you.

"Physician, Heal Thyself," quoted from St. Luke (Chapter 4, Verse 23), bears careful thought by each of us. We, as a profession and as individuals, need to set an example for the rest of the nation on how to conduct healthy lives. We must assimilate the stressors so we are not only survivors, but examples of *successful* survivors.

Government is not through with us yet. I have little doubt (as I have expressed before) that a national health plan of some sort will be our lot before the turn of the century. Witness the presidential candidates and their debates. Listen to the people of our state, as well as those in New Hampshire, where the first presidential primary occurs this month. The social ills in this country are out of control, and medical care or the lack of same for so many people multiplies the concern.

We physicians must be able to deal with these changes, keep our sanity, and continue to provide the best care we are capable of giving. We must be physically and mentally at our best to meet the challenges we will face.

My R_X is not new or original, but it works: be serious about your 1992 resolutions, and make them your standard as you head for the turn of the century. "Physician, Heal Thyself."

One to One is a series that invites physicians to ask questions about Pennsylvania Blue Shield.

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One to One.

Has there been an increase or decrease in the amount of Medicare Part B benefits paid out in Pennsylvania over the last several years?

Since 1985, the amount of Medicare Part B benefits paid in Pennsylvania has jumped from $1.1 billion to over $2 billion. That's an increase of almost 76 percent that can be attributed to a number of factors — including an overall increase in demands for services, new advances in technology and changes in the way medicine is practiced.

Despite a general aging of the population across the nation, the number of Medicare beneficiaries has not increased dramatically in Pennsylvania. Over the last several years the total has remained at approximately 1,900,000 people.

The increased Medicare Part B payout corresponds with a 53 percent increase in the number of claims processed over the last six years. As the Medicare Part B Carrier for Pennsylvania, Blue Shield processed 29,348,808 Medicare claims for the state in 1990. That is over 10 million more than the 19,216,040 processed in 1985.

Concurrent with the increases in the number of claims, Pennsylvania Blue Shield's Government Business Unit has had to increase staff and update its technology. That has allowed us to continue processing claims and providing reimbursements to physicians in a timely manner.

One of these technological updates was discussed in the last issue of *One to One*. Providers can submit claims electronically to Blue Shield by using their personal computers and a modem. This is known as "electronic claims submission" or ECS.

And, in light of the increases in the number of claims processed, the use of ECS would benefit everyone by eliminating paperwork and helping speed up the turnaround of reimbursements.

Here are the year to year numbers:

Benefits Paid

1985	$1.1 billion
1986	$1.3
1987	$1.4
1988	$1.6
1989	$1.7
1990	$2.0

Claims Processed

1985	19,216,040
1986	19,553,822
1987	22,363,739
1988	24,238,785
1989	26,245,894
1990	29,348,808

Has the national total for Medicare Part B benefits risen over the last six years?

Yes. Just as Pennsylvania's total rose, so did the nation's. The Health Care Financing Administration, which administers Medicare, paid out $108.9 billion in 1990 — or $38.5 billion more than in 1985.

Here are the year by year totals:

Benefits Paid

1985	$70.4 billion
1986	$75.7
1987	$81.7
1988	$88.5
1989	$100.3
1990	$108.9

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Of Medicine and the Environment

Robert N. Moyers, MD



Next month the State Society is sponsoring a public forum to discuss a proposal for a hazardous industrial waste incinerator to be located in Union County. Substantial public opposition has been generated as a result of growing concerns about public health and safety. The Union, Lycoming, and Montour county medical societies have joined in this opposition.

The state Department of Environmental Resources (DER) has begun public hearings on the incinerator, to be built by USPCI of Pennsylvania, Inc., and DER expects to make a decision on the company's site permit application by March 12.

Public health and safety has been a focus of organized medicine from the very beginning, and your Society carries on that concern.

In fact, about a year ago, the Board of Trustees adopted a policy statement by the then Commission on Public Health and Toxic Substances (now the Commission on Environmental and Occupational Health) about the incineration of hazardous wastes, in general, and about the Union County facility. The policy lists 47 issues and questions regarding the technical, safety, and regulatory aspects of hazardous waste incineration.

These issues remain germane today. They include such matters as the identity of the toxic substances to be handled in the facility, the limits of safe human exposure, the nature of incineration by-products, the characteristics of the incinerator itself, the details and cautions relating to transportation of materials to and from the site. Other issues include the impact on the local community infrastructure, tax base, property values, and emergency personnel. Preeminent among these, and implied in each of them, is the concern for the public good.

The policy statement, which has been released in the news media at least twice since it was adopted, reflects the Society's generally neutral stance on the concept of incineration.

However, we also want to promote continued attention to public health issues, and we cannot support the USPCI project until there are satisfactory answers to questions raised by the medical societies and by those who will live near the proposed incinerator.

Toward the end of December, I received a letter from George C. Miller II, MD, of Lewisburg, requesting that the Society become involved in the public discussion about the incinerator during the several weeks before the DER decision about the Union County incinerator.

David Brill, MD, of Geisinger Medical Center, an expert in environmental health matters, has been actively involved in the Union County discussion, as has Immediate Past President Gordon K. McLeod, MD.

I have called for a forum of experts to be convened to discuss the issue in detail, to explore the medical aspects of this controversy. Your Society is, and ought to be, in a position of leadership with regard to public health policies.

As physicians, we help to generate certain kinds of hazardous waste, and we are mindful of our serious responsibilities to help find solutions for its disposal. We will *not* add our voices to the NIMBY forces, whose only concern is that incinerators and other facilities be located somewhere else — and Not In My Back Yard.

The proper role of your Society in this issue is to search out the truth, based on scientific evidence. We want to foster the dissemination of good, solid, expert information that will enable decision-makers to properly assess the impact of the proposed incinerator on the public health and welfare.

We do not expect to find ourselves in the midst of every licensing discussion for every waste facility. However, when our colleagues see sufficient cause for concern in their communities, we will offer assistance where we can and leadership where it is our responsibility to do so.

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Understanding the New Medicare Fee Schedule

The methodology for determining the Medicare allowance for physician services changed effective January 1, 1992. Prior to the new year, the allowance for most physician services was determined by the reasonable charge system; now, however, the Medicare allowance for most physician services is determined by the resource based relative value scale (RBRVS) fee schedule system. The RBRVS fee schedule is being phased in over a five-year transition period.

Determining the RBRVS fee schedule amount is extremely complex; however, physicians need not calculate those numbers. Fee schedule amounts will be calculated by the state Medicare carrier, Pennsylvania Blue Shield (PBS), and physicians can obtain those amounts from PBS (see sidebar on page 12).

The formula

Under RBRVS, the Medicare allowance is the lesser of: 1) the physician's actual charge; and 2) the RBRVS or transition fee schedule amount, adjusted in some cases by Medicare payment policies. The formula for computing the RBRVS fee schedule amount is shown in Graphic 1.

The RBRVS fee schedule amount is the product of three numbers:

- The relative value units (RVUs) for the service, calculated from the total RVUs for three components: physician work, practice expense, and malpractice expense;
- The geographic adjustment factor (GAF) for the service in the locality where it was rendered, which is the weighted average of the geographic practice cost indices (GPCIs) for each RVU component (see Graphic 2); and
- A national monetary conversion factor (CF), which transforms the GPCI-adjusted RVUs into payment amounts. Currently, a single national CF applies to all services except anesthesia; in the future, different categories of services could have different CFs due to different updates.

In contrast to the reasonable charge system, which permitted prevailing charges to differ by specialty, the RBRVS payment levels do *not* differ by specialty.

Transition

Both nationally and in Pennsylvania, approximately one-third of physician services moved directly to the RBRVS fee schedule as of January 1, 1992. The remaining two-thirds are being phased in, and by 1996 all physician services will be paid based exclusively on the RBRVS fee schedule.

Transition determinations depend upon the interrelationship of the 1992 RBRVS fee schedule amount and the adjusted historical payment base (AHPB). The HPB (historical payment base) basically is the weighted average 1991 Medicare allowance for the service in the lo-

The information in this article is taken in part from the "Medicare RBRVS Payment System," a monograph prepared by the State Society's Department of Medical Economics and distributed to attendees of the Society's regional meetings in January on Medicare payment reform. Member physicians who did not receive a copy of the monograph may request one copy by calling the Society's Department of Physician Services.

Graphic 1

RBRVS FEE SCHEDULE FORMULA

$$F = [(RV_w \times GPCI_w) + (RV_p \times GPCI_p) + (RV_m \times GPCI_m)] \times CF$$

F	RBRVS fee schedule amount
RV_w	The work relative value units for the service
RV_p	The practice expense relative value units for the service
RV_m	The malpractice expense relative value units for the service
$GPCI_w$	The work GPCI in the locality
$GPCI_p$	The practice expense GPCI in the locality
$GPCI_m$	The malpractice expense GPCI in the locality
CF	The national conversion factor

Graphic 2

GEOGRAPHIC PRACTICE COST INDICES (GPCIs) FOR PENNSYLVANIA

LOCALITY NUMBER	LOCALITY NAME	WORK	PRACTICE EXPENSE	MALPRACTICE
1	Philly/Pitt	1.014	1.014	1.552
2	Large PA Cities	1.008	1.001	1.440
3	Small PA Cities	0.984	0.945	0.986
4	Rest of PA	0.975	0.929	0.986
Statewide	Statewide	0.997	0.978	1.268

In order to compute the geographic adjustment factor (GAF) for a service in a locality, a GPCI is calculated for each RVU component. As shown, four localities have been set up for Pennsylvania. The use of one statewide locality is an option currently under review.

The indices for each locality reflect the relative cost of the component compared to the national average. Each recognizes the variation from the national average: the variation for practice and malpractice expense GPCIs is weighted at 100 percent, and the variation for work (cost-of-living) GPCIs is weighted at 25 percent (as directed by law). For example, the Locality I malpractice GPCI is 1.552, meaning average malpractice premiums in that locality are 55.2 percent higher than the national average.

cality. The AHPB is the HPB increased by the 1992 update of 1.9 percent and decreased by a 5.5 percent adjustment imposed by HCFA to ensure budget neutrality during the transition. (For an explanation of the phase-in determination and transition formulas, see Graphics 3-5.)

Locality

There are four localities in Pennsylvania: 1) Philadelphia/Pittsburgh, 2) large Pennsylvania cities, 3) small Pennsylvania cities, and 4) the rest of Pennsylvania. Pennsylvania had the same localities for purposes of calculating prevailing charges under the reasonable charge system, with three exceptions: Geisinger Medical Center, Guthrie Clinic, and Lankenau Hospital were placed in a locality *outside* their geographic area prior to RBRVS. Under RBRVS, these facilities are *within* their geographic areas.

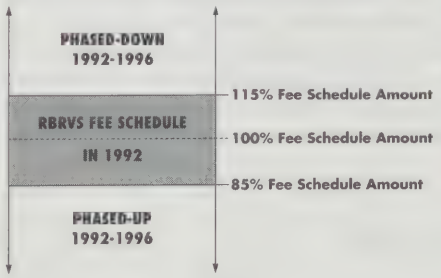
Impact of RBRVS

The AMA has developed several simulations of the impact of RBRVS; however, many physicians will experience an impact different from AMA simulations, and the full effect of RBRVS will not occur until 1996. In addition to inevitable forecasting errors, variances may occur due to:

- averages: the simulations are averages, and the actual impact will vary by service, specialty, and geographic area;
- AHPB impact: the AHPB can be significantly less than a physician's 1991 payment for two principle reasons: 1) the AHPB is not specialty specific, and 2) the AHPB included a 5.5 percent asymmetry reduction; if the AHPB is the culprit, physicians will attain expected gains by 1996;
- new physician reductions (for detailed information, see "New Physician Reductions Under Medicare" on page 13), non-participating physician penalties, and new Medicare coding and payment policy changes: some physicians may be

Graphic 3

PHASE-IN DETERMINATION



The above phase-in determination chart can be used for all services except radiology and anesthesiology services, which have their own determination methods. Phase-in occurs as follows:

- **A service moves directly to the RBRVS fee schedule in 1992 if the AHPB for the service is within 15 percent of the 1992 RBRVS fee schedule amount.**
- **A service is phased *up* to the RBRVS fee schedule from 1992-1996 if the AHPB for the service is less than 85 percent of the 1992 RBRVS fee schedule amount.**
- **A service is phased *down* to the RBRVS fee schedule from 1992-1996 if the AHPB for the service is greater than 115 percent of the 1992 RBRVS fee schedule amount.**

taking multiple hits in addition to payment-per-service reductions as a result of the RBRVS fee schedule.

Conclusion

Though implementation of the Medicare payment reform occurred on January 1, the AMA House of Delegates, at its interim meeting in December, did not endorse the system as it now stands. The delegates adopted a report of the Board of Trustees which directs the AMA to pursue several revisions to the system, including:

- extension of HCFA's grace period on the new visit codes;
- immediate analysis of the implementation of the payment schedule, focusing on whether carrier implementation is consistent with Medicare law and HCFA regulations;
- prevention of further reduction of current Medicare limiting charges;
- replacement of the "current flawed proxy data basis" for the GPCIs; and
- establishment of a program to monitor changes in patient access and physician practice patterns.

The report also includes provisions to assist physicians and carriers during the transition period.

In Pennsylvania, the State Society is in the process of developing policy on a number of related issues, including the interim work RVUs and whether to support a statewide locality. Also, the Society is offering a series of publications and CPT coding seminars to help members.

Society members, who have questions regarding RBRVS or other physician payment reform policies being implemented with RBRVS, should call the Society's Department of Medical Economics at 1-800-228-7823 for assistance. Members interested in Society publications and educational meetings may call the same number and ask for the Department of Physician Services.

HOW TO...

...Comment on Work RVUs

Write to HCFA, Department of Health and Human Services, ATTN: BPD-712-F, P.O. Box 26688, Baltimore, MD 21207. Deadline: March 24, 1992.

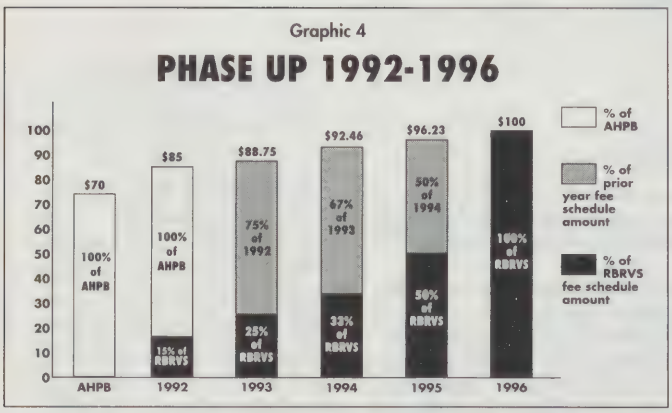
...Obtain Fee Schedule Amounts

Write to Pennsylvania Blue Shield, Medicare Provider Reimbursement, Inquiry and Monitoring, P.O. Box 890316, Camp Hill, PA 17089-0316; or call (717) 763-6622 for fee schedule amounts or (717) 763-5700 for limiting charges. Provide the following information: provider number, procedure code(s), and charge class area. Limit: five procedure codes per call.

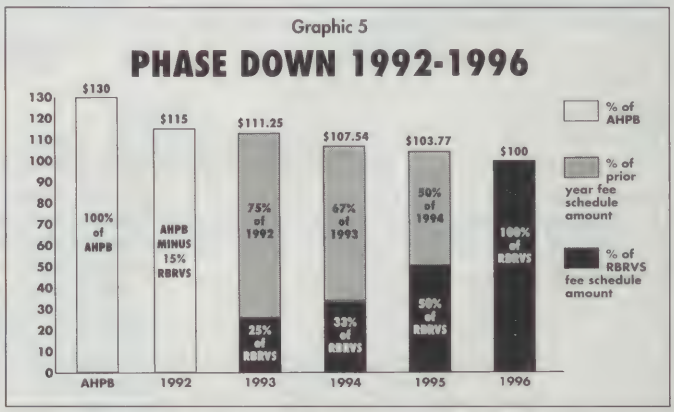
...Obtain Copies of the Final RBRVS Regulation

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Graphic 4



Graphic 5



In 1992 the fee schedule amount for a service phased into the RBRVS fee schedule is a blend of the AHPB and the 1992 RBRVS schedule amount. If the AHPB is less than 85 percent of the 1992 RBRVS amount, 15 percent of the amount is added to the AHPB. If it is greater than 115 percent, 15 percent is deducted. From 1993 through 1995, the fee schedule amount for a service phased into the RBRVS fee schedule is a blend of the prior year payment (adjusted by the current year update) and the RBRVS fee schedule payment as shown. Note: the example transition payment levels for 1993-1996 presented in these graphics do not reflect any updates, since they have not yet been established.

New Physician Reductions Under Medicare

Medicare fee schedule amounts are reduced for new physicians during their first through fourth years of practice with limited exceptions. While these reductions applied prior to the new Medicare payment system, they are impacting many new physicians for the first time under the new system. Previously, the Health Care Financing Administration (HCFA) did not apply the reductions to physicians in group practices. That exception no longer applies.

New physician reductions are based on a percentage of the Medicare fee schedule amount as follows: 80 percent for the first year, 85 percent for the second year, 90 percent for the third year, and 95 percent for the fourth year.

Exceptions

The new physician reductions do not apply in the case of primary care services, which are defined by HCFA as the following procedure codes: Office visits (codes 99201-99215); emergency department visits (codes 99281-99285); home visits (codes 99341-99353); nursing facility visits (codes 99301-99313); rest home visits (codes 99321-99333), and new patient ophthalmological services (codes 92002, 92004).

The reductions also do not apply to services provided in a rural Health Professional Shortage Area (HPSA). Services provided in a rural HPSA should be coded with the "QB" modifier. Appropriate use of that modifier will exempt the services from the new physician reductions, as well as qualify the service for an HPSA bonus payment. (For more information, see the HPSA map on page 16.)

Defining the first through fourth years

The first year of practice *begins* when the physician first provides a Medicare Part B service and *ends* on December 31 of the first calendar year during which the physician provided Medicare Part B services during:

- April through June of the year for years prior to 1990, or
- January through June of the year for 1990 and thereafter.

The second, third, and fourth years of practice are the second, third, and fourth calendar years, respectively, following the expiration of the first year.

HCFA will consider a physician to have provided Medicare Part B services during January through June of a year *only if* the physician provided a Medicare Part B service during January of the year. For example, if a physician began providing services in January 1992, the first year of practice expires December 31, 19**92**. However, if a physician began providing services in March 1992, the first year of practice expires December 31, 19**93**.

Medicare Part B services

A physician must provide *Medicare Part B* services to begin the first year of practice. Services provided to patients who are not Medicare beneficiaries do not qualify. For example, a military physician, who spent 10 years exclusively treating military personnel and their families covered by CHAMPUS, would be considered a new physician when leaving the military and beginning to treat Medicare Part B beneficiaries.

Services provided to Medicare patients *within* a residency program also do not qualify, since they are covered by Medicare Part A. On the other hand, services provided *apart from* the residency program while the resident is "moonlighting," either outside the training facility or in the outpatient department or emergency room of the training facility, may qualify.

The services of a resident in "moonlighting" settings are covered by Part B, as opposed to Part A, when: 1) the services are not related to the resident's training program; 2) the services are identifiable physician services, the nature of which requires performance by a physician in person and contributes to the diagnosis or treatment of the patient's condition; 3) the resident is fully licensed to practice by the state in which the services are performed;

The information in this article is taken in part from the "Medicare RBRVS Payment System," a monograph prepared by the State Society's Department of Medical Economics. See page 10 for more information about the monograph.

and 4) in the case of services provided in the outpatient or emergency department of the training facility, the services performed can be separately identified from those services that are required by the training program.

In addition, it is not necessary for the physician to actually submit claims to Medicare Part B for the service to qualify. It is only necessary for the service to be *covered* by Medicare Part B. For example, a physician can provide services covered by Part B while employed by an HMO. Those services qualify even though the HMO is reimbursed for the services.

"In essence, the Bush administration believes that the services of new physicians are worth less than those of other physicians."

Purported rationale

Initially, the federal government claimed the new physician reductions were necessary to remedy an inequity created by the reasonable charge system, then used to determine the Medicare allowances for most physician services. Under that system, the customary charge of a new physician—i.e. one who had insufficient charge data to calculate a customary charge—was set at the fiftieth percentile of the customary charge of physicians in the same specialty and locality. Because of that rule, it was possible for a new physician to be paid at a higher rate than a more experienced physician.

In 1990 the Bush administration advanced a new rationale. In an appearance before the House Ways and Means Health Subcommittee last spring, HCFA Administrator Gail Wilensky, PhD, testified in support of the OBRA '90 legislation, stating: "The vast majority of American workers earn more as they gain experience." In essence, the Bush administration believes that the services of new physicians are worth less than those of other physicians.

Prospects for change

The AMA has opposed new physician reductions from the outset and is seeking to have them eliminated. Because the reductions are mandated by law, a legislative reversal is required. Legislation which would eliminate the new physician reductions has been introduced by Representative Ed Towns of New York.

The projected savings from new physician reductions are estimated at $580 million during the five-year fiscal period 1991-1995. Under the terms of the 1990 budget agreement, elimination of these savings would have to be "offset" by other savings, cuts, or increased taxes. Because of the linkage between eliminating the new physician reduction and replacing the savings, convincing Congress to adopt Representative Towns' bill is a monumental task. The AMA Young Physicians' Section has issued a Legislative Alert urging young physicians to help its legislative representatives fight for passage of Representative Towns' bill (see "Call to Action" below).

Important advice

In the meantime, because of the new physician reductions, residents should consider moonlighting so their resident years qualify as new physician years. Also, physicians beginning to provide Medicare Part B services to Medicare beneficiaries for the first time should consider beginning in January so they will not be subject to the first-year reduction for longer than a 12-month period.

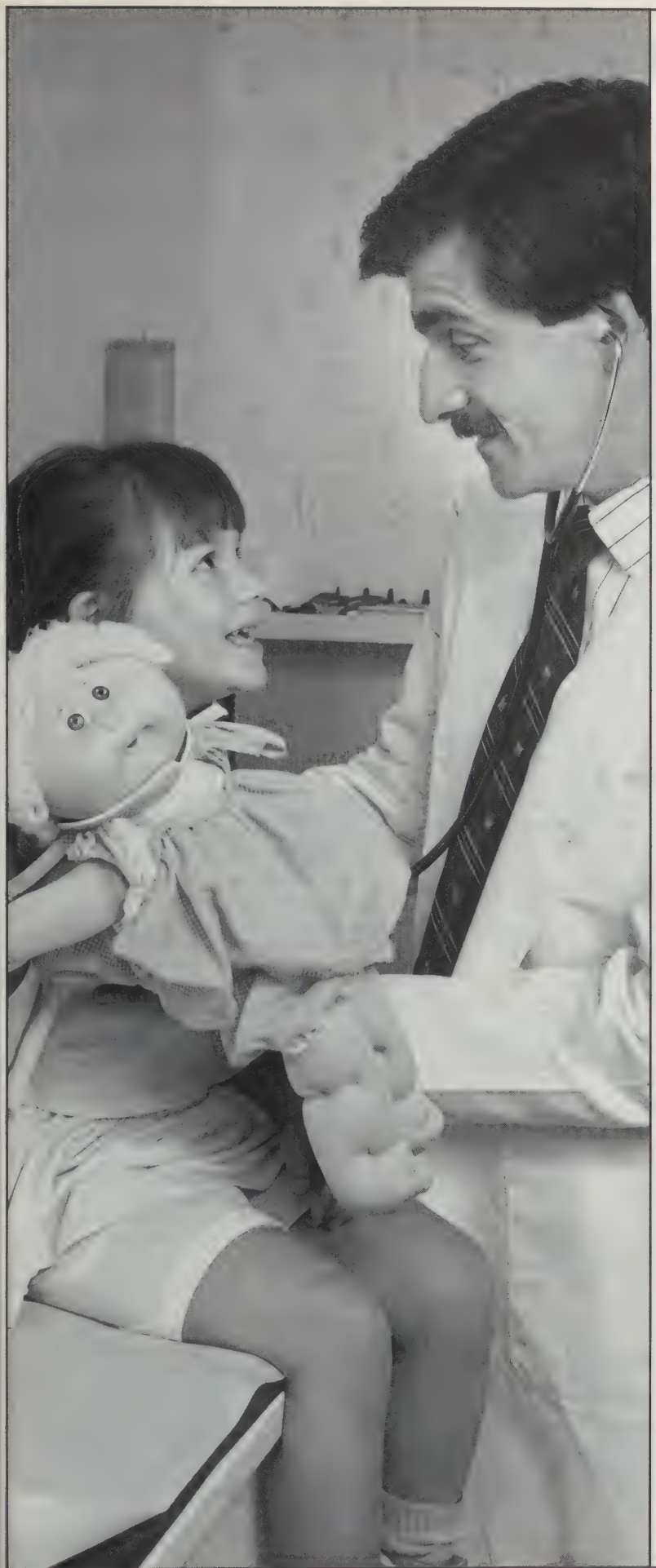
CALL TO ACTION

Call and write your member of Congress and senators at both their home and Washington addresses:

- Let them know the rationale for repealing those provisions that discriminate against young physicians (see "Talking points").
- Ask them to support repeal of Section 1842(b)(4)(F) of the Social Security Act (42 USC 1395u(b)(4)(F)) and to contact members of the House Ways and Means Committee, the House Energy and Commerce Committee, and the Senate Finance Committee.
- Ask other physicians and groups to support repeal.
- Send copies of your letters to the Pennsylvania Medical Society Council on Governmental Affairs, 777 East Park Drive, Harrisburg, PA 17105-8820.

Talking points

- The law is nothing more than a tax on young physicians designed to achieve arbitrary budget cuts.
- The law violates the concept of Medicare payment differentials being determined on the basis of resource costs, a concept adopted by Congress in landmark payment reform.
- Reimbursement rates under Medicare have not been and are not supposed to be based on mere prejudice. To say that a young physician's services are worth less because he/she has not been in practice as long as older physicians is simplistic.
- No data exists indicating that young physicians have lower resource costs for their practices. In fact, the cost of education, lost opportunity costs for years of training, professional liability costs, and costs of starting a practice are often higher for new physicians than for others.
- Such an approach penalizes the group of physicians who most likely have high Medicare patient populations and who accept claims on an assigned basis.
- Such an approach may discourage physicians from seeking training in the lower-paying specialties, so they can meet their educational and other debts.



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RBRVS COVERS LIMITED LICENSE PRACTITIONERS

Medicare law uses the term "physician" to refer to certain limited license practitioners (including optometrists, dentists, podiatrists, and chiropractors), as well as medical and osteopathic doctors. These practitioners are also covered by the new Medicare payment system.

The Health Care Financing Administration (HCFA) has elected to pay these practitioners at the same level as physicians when they provide an identically coded service. For example, the relative value units (RVUs) for foot surgery are the same regardless of whether the surgery is performed by an othopedic surgeon or a podiatrist.

Both the State Society and the AMA are opposed to the HCFA policy, because it ignores the differences between physicians and limited license practitioners: physicians have more extensive education and training, and pay higher malpractice premiums. Organized medicine believes that while the services may be identically coded, the resources used would be quite different and should be recognized.

As a result of a resolution introduced by the Pennsylvania delegation at the December 1991 AMA interim meeting of the House, the AMA is developing documented evidence of the differences to use to seek reversal of the HCFA policy.

UNDERSTANDING THE "UPIN" FROM HCFA

The Unique Physician Identification Number (UPIN) is a Medicare-specific, six-character identifier consisting of one letter and five numbers. It is assigned to physicians by HCFA and used to identify physicians who have referred patients to or ordered services from another physician.

A *referring physician* is defined as a physician who 1) requests an item or service for the beneficiary, including a request for a consultation with a specialist physician; or 2) requests or establishes a plan of care which includes the provision of an item or service. An *ordering physician* is a physician who orders non-physician services for the patient, such as diagnostic laboratory tests, clinical laboratory tests, pharmaceutical services, durable medical equipment, or the technical component of diagnostic tests.

Implementation

Effective January 1, 1992, the name of the physician and UPIN are required for Medicare claims for all referred or ordered services. The information should be reported in Block 19 of the current HCFA 1500 claim form. The UPIN is also required on Certificates of Medical Necessity (CMN) when the physician prescribes home oxygen. The UPIN should be reported next to the physician's signature. Additionally, when prescribing durable medical equipment, the UPIN should be reported on the CMN or beside the physician's name on the prescription.

Effective January 1, 1992, claims received without UPINs will be rejected by Medicare, and resubmission with the information will be required.

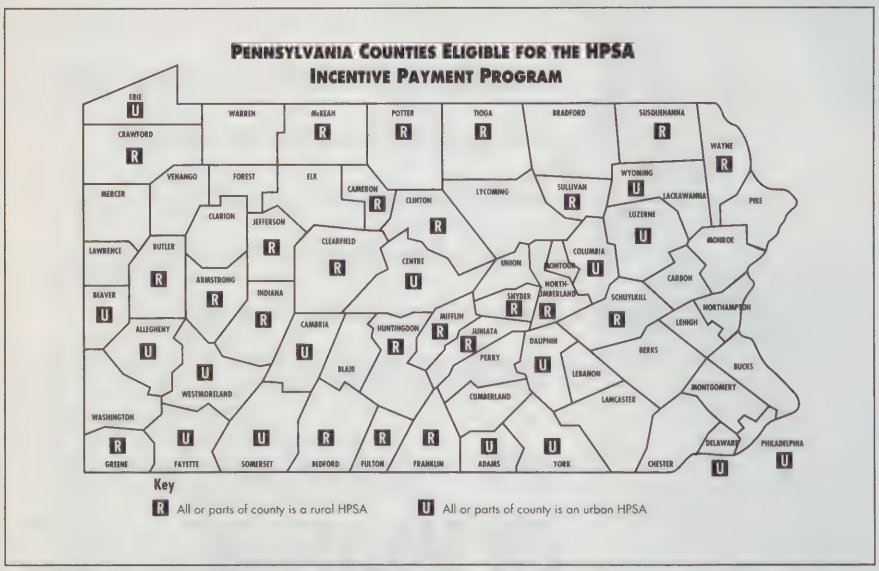
Surrogate UPINs

In some situations, physicians have not been issued UPINs. "Surrogate" UPINs would be used for interns and residents, physicians retired from practice prior to the issuance of UPINs who are not currently billing Medicare, and physicians serving with the Veterans Administration and other non-Medicare involved practice settings, such as the Public Health Service. A surrogate UPIN also exists for self-referrals, where the beneficiary obtains a service without an attending physician's referral. This may occur with podiatry, optometry, ambulance, and physical therapy services.

Obtaining a UPIN

Most physicians have received information about their UPIN by now, but those who have not should make a Request for Assignment by writing to: Pennsylvania Blue Shield, P.O. Box 898842, Camp Hill, PA 17089-8842. Include: physician's name and practice address; Medicare provider number; name of medical school and graduation year; medical license number; and whether a UPIN was previously applied for, and if yes, the month and year of application. Call Sandy Mitchem, Pennsylvania Blue Shield, at (717) 975-3001 for additional information about obtaining a UPIN.

To obtain UPIN information about a referring physician, first attempt to



PHYSICIANS DUE BONUSES IN PENNSYLVANIA HEALTH PROFESSIONAL SHORTAGE AREAS
Physicians are entitled to a bonus payment, in addition to the Medicare allowance, when they perform a service in a Health Professional Shortage Area (HPSA). The state map above shows that all or part of 40 Pennsylvania counties are HPSAs. The bonus payment is equal to 10 percent of Medicare's share of the allowance and applies to both assigned and unassigned claims. HPSA payments are made on a quarterly basis, *BUT physicians must apply for them.* To do so, code the service with the appropriate modifier: "QB" for rural and "QU" for urban. Direct any questions to the State Society or Pennsylvania Blue Shield.

do so from the referring physician. If unsuccessful, write to: Pennsylvania Referring Physicians, Medicare—Pennsylvania, P.O. Box 890317, Camp Hill, PA 17089-0317.

UPIN directories listing all physicians and their UPINs by state are available free of charge from Pennsylvania Blue Shield.

For additional information, call the Society's Council on Medical Economics staff at 1-800-228-7823 or Pennsylvania Blue Shield at (717) 763-6589.

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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

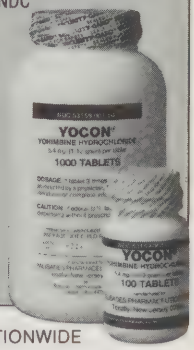
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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Responding to the Workers' Compensation Crisis

A proposal on the structure and management of workers' compensation programs

Herbert E. Segal, MD, MPH

In 1990 job-related injuries are estimated to have cost American employers over $60 billion in direct workers' compensation expenses, a figure which has doubled in the past four years and which may do so again by 1995.[1] The medical costs of treating work-related injuries and illnesses are estimated to have consumed 41 percent of workers' compensation payouts for 1990, the remainder by indemnity claims costs.[2] Taken together with a 17.1 percent increase in group health care costs in 1990,[3] there is concern for the maintenance of a reasonable business atmosphere[4] under which businesses may remain competitive and prosperous, and employment will be available.

"The objective [of KePRO] is to insure the delivery of quality medical care while containing costs, whether or not there is legislative change."

Fueled by a possible 52 percent increase in insurance rates,[5] the governor, legislature, business community, and labor, among others, have begun to critically reexamine the direction and management of workers' compensation programs. The Pennsylvania Medical Society has been actively involved in these discussions and has developed a legislative approach to cost containment. While much of the discussion on workers' compensation cost containment strategies has focused on control of physicians' costs, usually through development of a fee schedule,[6] KePRO's response to the expressed interest of several large insurers has been to develop a more comprehensive management strategy. The objective is to insure the delivery of quality medical care while containing costs, whether or not there is legislative change.

KePRO's strategy

The effort envisioned is significantly broader than current proposals and might usefully be divided into pre-injury, acute post-injury, chronic post-injury, and rehabilitation phases. The program management initiatives relevant to each phase are listed in the table at right, with the understanding that some overlap does occur. The 17 initiatives are listed in descending order of employer preference.[7]

KePRO and other quality assessment/utilization review organizations, working with workers' compensation carriers and self-insured businesses, face a daunting task, i.e., developing a comprehensive, consistent approach. KePRO has chosen to recognize the importance of the pre-injury and rehabilitation phases, but concentrate its efforts in the review of care provided in the acute and chronic post-injury phases ("KeyCare"). We have taken as a statement of purpose evaluating, communicating, and facilitating the injured workers' return to the workplace; evaluating services and expenses certifiable as being of high quality and as medically appropriate; and communicating cost-effective alternatives, providers, services, and treatment sites.

Within the pre-injury phase, KePRO works with carriers and self-insured companies to develop thresholds for injuries which require review of care. It is not efficient to review all care provided, since many injuries are self-limited and return to work is prompt. Referrals for review should be considered when hospitalization, anticipated indemnity, or treatment over certain time or dollar thresholds, surgery, or catastrophic injuries occur. If a record is received for review in the acute post-injury phase, i.e., the injury has occurred within the past 26 weeks, as a rule, concurrent review is initiated. This review may include precertification as well as assessment of ongoing care.

Upon receipt of a request for concurrent review, KePRO conducts a telephone interview with the injured worker. In this interview, the worker provides demographic data, a description of the accident and injury, a summary of the care provided to that point, and the identity of the treating practitioner. The interviewer es-

Dr. Segal is central medical director of the Keystone Peer Review Organization.

tablishes a caring, friendly relationship with the worker, expresses interest in facilitating the workers' early return to the workplace, and schedules follow-up phone calls keyed to the next visit with the practitioner or scheduled diagnostic procedure. The data obtained through the initial and subsequent interviews are subjected to an expert system analysis to determine if care provided is appropriate to the diagnosis, physical findings, etc.

KePRO also notifies the attending practitioner by mail that the care being provided is under review because of the threshold anticipated or reached. The physician is provided with an exact description of the workers' duties, to be a guide in making decisions as to when the worker is able to return to the job. This is also an appropriate opportunity to describe the employer's light-duty or work-hardening program, if one is available. No further contact is made with the practitioner unless the expert system raises a flag suggesting the value of a peer-to-peer contact.

If a question about the care being provided is in fact raised, a KePRO physician or other professional will phone the attending practitioner to clarify the diagnosis or treatment plan. An effort is made to reach a consensus on a proposed treatment plan or a return to work. The value of resolving issues in discussion between peers cannot be overemphasized. If that cannot be accomplished, impasses are reported to the insurer or employer. Telephone contacts with the worker and the practitioner, when appropriate, continue until the case is closed and/or the worker returns to duty.

Insurers and employers may have substantial backlogs of unresolved cases; KePRO conducts retrospective review of these cases. This includes a utilization review and a hospital bill or fee audit. These audits are done utilizing the appropriate fee schedule agreed upon with the insurer/employer or the schedule mandated by state law. Expert systems are also available to address issues such as unbundling and duplicate billings of the employee's group health coverages. KePRO recommends, on the basis of retrospective review, which billed charges should be approved and which should not.

WORKERS' COMPENSATION MANAGEMENT INITIATIVES BY PHASE

	Pre-Injury	Acute Post-Injury	Chronic Post-Injury	Rehabilitation
Safety Programs	X			
Pre-Employment Screening	X			
Light-Duty Programs				X
Vocational Rehabilitation				X
Medical Bill Audits			X	
Claims Administration Audits		X	X	
Job/Task Analyses	X			
Litigation Management			X	X
Fee Schedule Compliance		X	X	
Use of Case Managers		X	X	X
Review of Physician Practice Patterns			X	
Use of HMOs, PPOs		X	X	
Pre-Certification		X		
Cost-Control Incentive Programs	X			
Rate Negotiations with Healthcare Providers	X			
Coordination with Group Health Providers	X			

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Apart from concurrent and retrospective review, there are several additional services KePRO proposes as useful to insurers and self-insured employers. One is assistance in preparation of depositions and testimony, given the volume of litigation and arbitration which currently occurs. Another is the development of tailored reports to identify workplaces or jobs at high risk for injury. Reports may also be developed to identify those practitioners and providers whose performance is consistently within or outside review parameters. A contract for review may also include the communication of review results to practitioners and providers. Such data could serve as a basis for re-examining performance and making modifications where appropriate.

Identification of administrative or program management expenses which could be eliminated should also be considered. It is possible, for example, to translate review decisions directly into payments for practitioners and/or providers through electronic means.

Management of workers' compensation programs is a complex venture which requires the commitment of the worker, the care provider, the employer and insurer, and the peer review firm when employed. All parties must focus on returning the worker to the workplace as promptly as possible and on facilitating that return through the exchange of information and the promotion of timely, appropriate, and properly priced care. Approaches which do not recognize the complexity of workers' compensation program management may achieve short-term gain, but at the peril of unbalancing or upsetting efforts at system reform. The KePRO approach is put forward as one way to address the acute and chronic post-injury phases within such reform.

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The Role of KePRO Medical Directors

Donald E. Harrop, MD

As I read through my KePRO mail, or when I have occasion to address a group of physicians, one issue that continually requires additional explanation is the role of our medical directors.

Often, questions asked of me imply that physicians believe KePRO medical directors are making review decisions, probably because their signatures appear on quality and utilization review determination letters. This is, in fact, not correct. All review decisions are made by credentialed physician advisors who are matched for the case under review by specialty or type of service provided. The medical directors do have the responsibility to assess reviews from the procedural perspective (e.g., "Did the proper physician specialist see the case?"), but otherwise their roles are quite unique. Five physicians hold these management positions.

The central medical director, Herbert E. Segal, MD, is responsible for overseeing all activities of KePRO's Medical Affairs Division. Reporting to him in this capacity are the director of medical affairs operations; the director of professional relations; the staff epidemiologist; the associate medical directors for Areas I, II, III, and central review; and the manager of associate medical director support services. These staff members are responsible for activities which deal with the performance and follow-up of physician review, from the actual recruitment and credentialing of physician advisors through the interventions/sanctions process.

As a member of the senior management staff of the organization, Dr. Segal is also involved in a number of other corporate functions such as the development of private review business and academic/research endeavors. He devotes a significant amount of his energy to maintaining positive relations with hospital medical staffs, specialty societies, and the physician and provider communities in general.

Our associate medical directors who work out of our area offices are: Kevin Kenny, MD, Area I; Alfred W. Meneely, MD, Area II; and Lester Sablosky, MD, Area III. They are responsible for ensuring that quality review policies, procedures, and interventions are implemented and monitored appropriately in their respective areas. Specific duties include analyzing physician data profiles, monitoring the appropriateness and effectiveness of quality interventions, assigning the specialized quality intervention physicians to manage specific case interventions, reviewing confirmed severity level III quality problem cases to determine whether immediate interventions should be taken, and referring cases that appear to require a higher level of decision-making authority (i.e., to the central medical director, Board of Directors, etc.).

The associate medical director for central review, Robert L. Tecau, DO, has similar responsibilities to the other associate medical directors in his newly created position, except that he oversees those physician review activities that are conducted only in the central office. These include: ambulatory surgery review, intervening care review, HMO review, and preprocedure review of assistants at cataract surgery.

Physicians do occasionally have concerns which they believe should be brought to KePRO's attention. If these concerns relate to individual case review, it is usually most efficient to communicate within the context of the review process, so that additional information can properly be considered by the physician advisor reviewing the case. If the review process has been completed, it is most appropriate to direct inquiries to the associate medical director responsible for the area office in which the review was conducted. Dissatisfaction with a response at that level should be directed to the central medical director or the Pennsylvania Medical Society Committee on KePRO Oversight, again understanding that only procedural issues will be addressed at those levels. Broader issues relating to the conduct of the KePRO physician review process in general or to specific specialty issues should be addressed to the central medical director.

One strength of KePRO is its commitment to physician management of the review process. The medical directors are in place to actuate that commitment.

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Donald E. Harrop, MD, is president of the Keystone Peer Review Organization.

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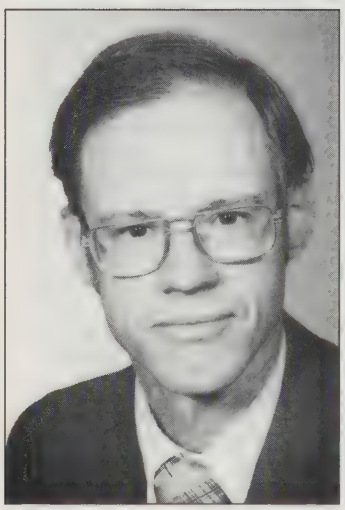
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Possible Health Effects of EMF

David R. Brill, MD

In the last 15 years, a new environmental health concern has emerged: electric and magnetic fields (EMF) associated with 60 hertz (Hz), alternating current (AC) electricity. Because recent reports in the popular press have stirred public attention, patients may well ask their physicians about it. The Soviets were the first to speculate about health effects from electric fields in the early 1970s. Other studies followed throughout the '70s and '80s. Public debate has grown to include concerns about household electrical appliances.



Dr. Brill is chairman of the State Society's Commission on Environmental and Occupational Medicine, and chief of the nuclear medicine section at Geisinger Medical Center, Danville.

The possible public health effects of electromagnetic fields (EMF) are not trivial given the ubiquity of electric lines and appliances. Physicians should be aware that their patients are beneficiaries of activities which create these effects.

Hospitals may be the source of higher-than-average exposures to EMF, considering their use of electricity and the number of devices that energy supplies. Electrically heated bassinets, electrocautery, electrically operated life support devices, computers, video display terminals, and virtually all radiographic equipment are sources of EMF. Magnetic resonance imaging (MRI) is far and away the most powerful source of magnetic fields to be found in hospitals. Employees and the public are shielded as carefully as possible. The American College of Radiology's Commission on Radiologic Units, Standards, and Protection (CRUSP) says that all commercial MRI units operate within guidelines set by the FDA as being acceptable, and exposure of personnel outside the scanner is less than 1/1000 of that of patients within the bore of the magnet.[1]

History of studies

The first serious suggestion of a carcinogenic effect was the study reported by Wertheimer and Leeper in 1979.[2] The researchers studied all deaths from childhood leukemia reported in Denver, Colorado, from 1950 through 1973, looking for associations with various environmental stimuli. They found that children dying of all leukemias were three times as likely as children who were healthy to live within two houses of a transformer which stepped down voltage from distribution lines to household levels. They concluded an association with EMF. The study made some assumptions, most notably that dose absorbed could be estimated from the size of the wires (and thus their voltage), that all forms of leukemia were equally likely to be induced, that no other environmental stimuli were present, and that socioeconomic status and lifestyle played no role in the differences between patients and controls. The study was not carried out in a blinded fashion.

In ensuing years, similar studies were undertaken in Rhode Island,[3] Sweden,[4] and elsewhere.[5,6] Many of the flaws of the original study were corrected. The results of these studies were mixed. Some concluded a small, but statistically significant correlation between EMF and leukemia; others found a trend, not significant; and still others found no relationship whatsoever. A very important study was carried out by Savitz[7] in Denver and reported in 1987. Using an entirely different group of leukemia deaths (1973 through 1980) and correcting many of the design flaws of the original review, he found a weak but significant correlation between the likelihood of leukemia and doses of EMF, estimated from actual measurement of flux. Reanalyzing his data using the cruder dosimetric techniques of the 1979 study, he closely approximated the Wertheimer-Leeper numbers. The same author performed a metaanalysis of 11 different studies[8] of EMF and leukemia, finding a marginally significant 1.2-fold increased risk among those exposed to high flux EMF as opposed to those who were not.

Leukemia is not the only cancer risk studied. Other studies have concentrated on adults, especially those exposed to high density EMF flux. Correlation between male breast cancer,[9] brain cancer,[10] and melanomas has been suggested. No study was able to compensate effectively for such confounding factors as exposure to chemical carcinogens, tobacco, etc. Moreover, many studies correlated high risk with job title—an electrician may be classified as having a high exposure, but in re-

ality, since most electricians work with the current turned off, actual exposure might be much lower. The inaccuracies introduced by such practices could bias a study either way. Such studies suggest a cancer risk from EMF which is at the lower border of statistical significance.

Other effects have been postulated. Wertheimer and Leeper[11] studied progeny of women who used electric blankets or electrically heated water beds and found a statistically significant incidence of low birth weight and slowed development. That heat might have produced such an effect was apparently not considered.

Numerous other studies are under way, but for now the possibility of somatic damage related to EMF exposure lies tantalizingly balanced upon the lowest levels of statistical significance. A great deal of reluctance to accept the possibility of health risk by the scientific and medical communities has been due to the lack of a plausible mechanism. In fact, for a long time biologic damage was thought to be due only to ionization or heating.

What is EMF?

Electricity moving in a wire is characterized by its voltage (V, a measure of energy) and its current (A, measured in amperes or amps, the number of electrons flowing). Multiplied together, voltage and current give the power (W, measured in watts). Thus, a given wattage may be maintained by increasing voltage while decreasing amperage or vice versa. This concept is important when considering transformers which may boost voltage for more efficient transmission of electricity over long distances or step it down for local consumption. In the U.S. and Canada, virtually all electricity is alternating current. Current oscillates through 360 degrees 60 times per second. The measure of a cycle per second is the hertz (Hz). North American power is 60 Hz AC.

Electricity moving in a wire will induce adjacent electrical and magnetic fields. Electrical fields are parallel to the flow of current and proportional to voltage (Figure 1A). Magnetic fields are perpendicular to the flow of current and proportional to amperage (Figure 1B). Both diminish in proportion to distance from the source. Electrical fields are strongly affected by environment and can be sharply attenuated by objects interposed between the source and the point of measurement. Magnetic fields, on the other hand, are attenuated by very little other than rather massive ferromagnetic structures. Alternating current introduces sine wave variations in the strength and direction of both electrical and magnetic fields. Interaction between AC fields from two sources can produce either accentuation or dampening of strength, depending on whether two peaks coincide (Figure 2A) or a peak and a valley (Figure 2B) occur simultaneously.

EMF may induce small fields and weak currents in other objects. Because electrical lines are sometimes grounded to underground plumbing, water and sewer pipes may act as secondary sources of EMF, as may other metallic objects. Appliances may also generate EMF. Video display terminals (VDTs), hair dryers, electric blankets, water beds, microwave ovens, and coffee makers have been shown to be the sources of strong (but generally very focal) EMFs. An appliance does not need to be running to be a source of an electrical field. If plugged in, a voltage difference exists, and nothing else is required. Magnetic fields occur only when the appliance is in operation. EMF can also interact with chemical ions, including those in the body, and herein lies the basis of the health controversy.

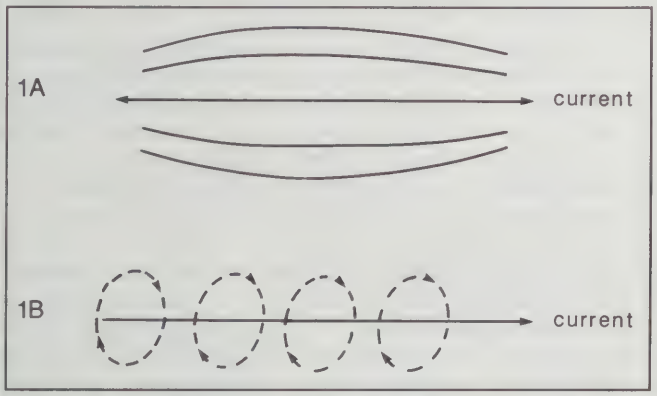


Figure 1A: Electrical field: As current flows, the field is generated parallel to the axis of flow.
Figure 1B: Magnetic field: As current flows, the field is generated radially around the axis of flow.

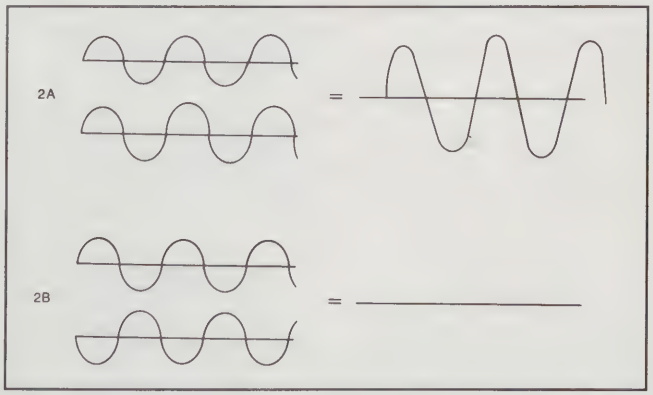


Figure 2A: Diagram of augmentation of electrical or magnetic field strengths when alternating current waves are in phase.
Figure 2B: Diagram of cancellation of electrical or magnetic field strengths when alternating current waves are completely out of phase.

1. **Volt**—unit of electrical potential or energy; a product of current times resistance. Volts = amperes x ohms

2. **Ampere**—unit of electrical current; the number of electrons flowing in a circuit. Amperes = coulombs ÷ sec

3. **Watt**—unit of electrical power; a product of potential times current. Watts = volts x amperes

4. **Gauss**—unit of magnetic field strength or intensity. The natural magnetic field of the earth is <1 gauss at the surface.

5. **Tesla**—10,000 gauss. Magnetic resonance imagers normally employ field strengths of 0.15-1.5 tesla.

Ionization can be caused by high energy electromagnetic radiation, such as x-rays, gamma rays, and ultraviolet light. Proteins and ribonucleic acids may be broken directly or by contact with ionized water species such as peroxides, hydroxyl ions, etc. EMF, having extremely low energy, is utterly incapable of ionization. Heating is a property of radar and microwaves. Low-energy EMF radiation is also incapable of imparting enough energy to heat anything. Other effects at the cellular level have come to light only recently. Although the existence of these effects is not disputed, no unified theory of how they relate to cancer induction has emerged so far. Investigational evidence is derived from whole animal experiments and cellular preparations. As with epidemiologic studies, numerous variables in experimental design, voltage, current, field strength, duration of exposure, and coexisting conditions make comparison and addition of results difficult. In the few cases where similar designs were used, results differ so that, as with epidemiology, no firm conclusions as to the magnitude of an effect can be made.

At the cellular level, three major effects have been seen repeatedly: 1) an alteration of the cell membrane which interferes with ion, especially calcium, transport into and out of the cell; 2) alterations in the transcription of information from DNA to mRNA and a subsequent change in protein synthesis; and 3) depression in the production of melatonin by the pineal gland.[12] Melatonin has been implicated in circadian rhythmicity and in suppression of tumors, possibly by limiting production of sex hormones.

A plausible, but by no means demonstrable, link to the somatic symptoms of Russian switchyard workers and the apparently increased incidence of male breast cancer among electricians, power plant workers, and linemen could exist. The intensity of EMF required to produce such effects is generally greater than is found in the environment, although some investigators have observed these changes at field strengths that are in the range of those found around utility power lines. Some researchers report changes only in cells pretreated with a mitogen, raising the possibility that EMF might act as a potentiator of cancers, not as a primary carcinogen.

EMF also produces effects in laboratory animals. Rats exposed to strong microwave fields have shown enhanced growth of mammary carcinoma induced by benzo-a-pyrene when compared to non-exposed rats.[13] This also hints at promotion vis-a-vis induction. Other work done with rats[14] shows definite suppression of melatonin in vivo when animals are exposed to fields of 0.8 gauss (roughly twice the field of the earth). Such rats experience a higher rate of spontaneous tumors, as do rats which are pinealectomized. Parenteral melatonin reverses the trend in pinealectomized rats. Experiments are under way to see if exogenous melatonin will protect rats exposed to EMF.

As with epidemiologic studies, a great deal of variability exists. Some studies strongly suggest a link with cancer, others show none at all. Equally disturbing is the apparent lack of a dose-response relationship. With virtually all other physical or chemical carcinogens, an effect becomes more pronounced with a stronger stimulus. Such is apparently not the case with EMF. A possible explanation of this phenomenon is that certain atoms are known to resonate at certain frequencies. Application of exactly the right field strength and frequency of electromagnetic radiation can cause those atoms to absorb energy and change their physical behavior. This principle is employed in MRI.

Observations from studies

Regardless of whether a biological effect exists or not, two observations are in order. First, biological effects do not necessarily translate to human effects, and any human effects which exist are rather small. Cells in a culture medium and rats in a cage are not the same as human beings in their homes, at work, or at school. The whole organism may have protective or compensatory mechanisms not present in a laboratory preparation. Furthermore, epidemiologic evidence is inconclusive. While a deleterious effect cannot be dismissed in the light of current evidence, any such effect cannot be very large.

Given the ubiquity of EMF in our environment, it is not reasonable to try to avoid it. Dr. Granger Morgan of Carnegie-Mellon University[15] offers three approaches. One, the simplest, is to ignore any concern about EMF. Such a position might be justified by citing the lack of consistency in epidemiologic data and the failure of all investigations so far to demonstrate any measurable hazard from EMF. This is the least expensive

from society's and the individual's perspective and could even be the safest from the standpoint of total society, considering that increasing the cost of energy could deny it to families in the lowest income brackets.

At the other extreme, failure to demonstrate a hazard so far does not mean that harm cannot be done. Using this approach, some might argue for greater rights of way for electrical distribution systems, more effective shielding, and the redesign of appliances to minimize stray EMF. This would certainly diminish ambient EMF, but at a potentially high cost. The price of land and cost of acquiring it would significantly elevate the financial investment in new electrical distribution systems and would have to be passed along to rate payers. Household appliances might or might not cost more, but the price tag associated with bringing public buildings such as hospitals into a lower EMF status needs to be thought through very carefully.

Morgan's third approach, "prudent avoidance," is a middle road. If it is easy and inexpensive to avoid exposure, then we should do so. For example, use an electric blanket to heat up the bed prior to retiring, but turn it off (and unplug it) upon getting into bed.

For individuals concerned about levels of EMF in their homes or on their property, many electrical utility companies will perform measurements at no charge. While these are accurate, they assess only what is present at that moment. Furthermore, no national standards for maximal EMF flux have been adopted, since the existence of a real hazard has been so hard to prove.

A balance needs to be achieved, however, since appliances and activities which generate EMFs benefit society. Alternate sources of energy and substitutes for EMF-emitting appliances may have other hazards which are equal to or even exceed that of EMF.

Utilities and appliance manufacturers are beginning to respond to concerns about EMF exposure. For example, a new electric blanket has been marketed with reduced EMF, and utility companies have looked at ways to reconfigure high-tension lines so their individual fields dampen rather than augment one another.

Theoretical, experimental, and epidemiologic evidence suggests a health hazard from EMF, but this is not conclusive and the hazard, if it exists, is apparently rather weak.

Unless stronger evidence of a hazard comes to light, the position of the Pennsylvania Medical Society should be that only prudent steps be taken to reduce the risk to those exposed to levels routinely encountered in the environment. Further research is needed to clarify whether a hazard exists to those occupationally exposed, and, if so, its magnitude and how to mitigate it. If patients are concerned, the strategy of "prudent avoidance" is a reasonable way of reducing exposure without losing benefits.

References available upon request.

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Harvard Medical School

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STATE'S NEW AUTO REGS DIRECTLY EFFECT PHYSICIANS

Since last fall, when controversial new auto insurance regulations became law in Pennsylvania, the state's medical providers have been dealing with the impact of these new rules. The following is an analysis of the new regulations from the State Society's Division of Governmental Affairs:

Act 6, the Pennsylvania Vehicle Financial Responsibility Law, including Automobile Insurance Medical Cost Containment regulations, became effective November 30, 1991. The auto regulation general rule states that payment for treatment of an insured resident by a licensed medical provider will be paid at the lesser of: 1) 110 percent of the applicable Medicare allowance charge, or 2) the provider's usual and customary charge. If no Medicare payment has been calculated, payment will be 80 percent of the provider's usual and customary charge.

Billing

According to the provisions, the 110 percent Medicare payment limit will be applied by insurers to provider services covered by an auto insurance policy. Within 30 days of *receipt* of the provider's bill, the insurer must inform both the provider and the insured when first-party benefits have been exhausted. At that time a provider may directly bill the insured or a secondary carrier for the remaining services. However, the provider's bill is limited to those services *not* paid under the primary policy.

In cases of multiple providers, insurers will pay bills as submitted, and if they are received at the same time, the lowest payment amount will be paid first. Medicare payment limits do not apply if the provider's bill is not covered under the insurance policy.

Coding

Part-B providers should use the HCFA Common Procedure Coding System, the HCFA 1500 form (or other current Medicare form in use), and provider diagnostic specific codes when available. *Unbundling* of charges imposed for specific care is not permitted except as consistent with the Medicare program, and changes to a provider code can only be made when the insurer has sufficient information to make the change and *after* provider consultation. Insurers must substantiate in writing their reasons for any coding change.

Peer Review

The Act includes several provisions related to peer review:

- An insurer must notify a provider in writing that their bills have been referred to a Peer Review Organization (PRO).
- PRO referral must be made within 90 days of the insurer's receipt of sufficient documentation supporting a bill.
- An insurer must pay any bill for care *not referred* to a PRO within *30* days of receiving sufficient documentation supporting a bill.
- If the insurer makes its referral after the thirtieth day, but on or before the ninetieth day, the provider's bill for care must be paid.
- PRO requests to providers for information must be in writing.
- Providers will have an opportunity to discuss their case with the reviewer and submit additional information prior to a final determination.
- The PRO initial determination must be completed within 30 days after the receipt of requested information *OR* 30 days after the request for information is postmarked.
- The PRO shall provide a written analysis (including specific reasons for its decision) to insurers, who must within five days of receipt provide copies to providers and insureds. Such notice should inform all parties that they have 30 days from the day the initial determination is effected to request reconsideration.
- An initial denial of a claim can only be effected by a licensed practitioner of like specialty or a licensed practitioner with experience providing and prescribing the care subject to the review.
- Any or all parties may request in writing a reconsideration of the initial PRO determination within 30 days from the date effected.
- A PRO may set a reasonable charge for a reconsideration but it may not exceed the charge for the initial review.
- *The insurer must make full payment to the PRO for the reconsideration*; ultimately, however, the cost is borne by the losing party.
- Reconsiderations will be conducted by a different licensed practitioner of like specialty than that which rendered the initial determination.
- A PRO must complete a reconsideration within 30 days after receipt of: the information used in the initial determination, new information in medical records, or additional evidence submitted by the requesting party.
- The insured may not be billed during the peer review process.

The following provisions relate to PRO standards, report responsibilities, and criterial for approval:

- The PRO must contract with an insurer for peer review services and may not mediate disputes for or engage in the administration of claims for insurers.
- Providers will be reimbursed the cost of copying records at the current rate HCFA reimburses its contracted PROs.
- Written notice of a determination must be mailed to the insurer within three working days of the conclusion of a PRO's review.
- PROs must submit annual reports to the insurance commissioner.
- PROs must apply in writing for the insurance commissioner's approval to contract with an insurer.
- A PRO may not be owned by a Pennsylvania licensed insurer and must certify that reviews are conducted by medical personnel licensed in this Commonwealth.
- A PRO may not charge for services on a percentage or contingency fee basis.

Provider complaints

To file a complaint, providers must first attempt to resolve it in writing with the affected insurer, who must send a response within 30 days of receipt. Only after a filed attempt at the resolution has been made may the provider submit the complaint to the Insurance Department.

For a complete copy of the auto regulations or additional information, call the Society's Division of Governmental Affairs at 1-800-228-7823.

Donald M. McCoy, director, and Frani Battista, assistant director of regulatory affairs and specialty legislation, contributed to this article.

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Diverse Leaders Strive for Common Goal

Maria T. Montesano
Assistant Managing Editor

Each year PENNSYLVANIA MEDICINE interviews the Society's newly elected trustees. Over the course of the next three issues, you will meet them and learn their interests and views on practice, politics, and organized medicine.

Next month:
Look for profiles of newly elected trustees, William R. Beltz, MD, and James R. Regan, MD.

Diverse as the following leaders' stories may be, their intentions as trustees of the Society center around one goal: to maintain high quality care for patients by participating in the political process affecting medicine.

The patient advocate

Since becoming involved in organized medicine in 1963, John W. Lehman, MD, the Society's new Tenth District trustee, has been active on all levels. In the State Society, he is immediate past-chairman of the Council on Medical Economics, secretary of the Governing Council of the HMSS, and a member of: the Commission on Access to Health Care, the Indigent Care Quick Response Committee, the Keystone Peer Review Organization Board of Directors, and several other committees. He is a past-president of the Beaver County Medical Society, and he serves as an alternate delegate to the AMA.

In 1958 Dr. Lehman graduated from Temple University School of Medicine, where he also completed his residency in orthopedic surgery. He then returned to his hometown in Beaver County to start a private practice, which he manages today with two partners.

"I've always wanted to be a doctor," he says. "I don't recall any particular reason why; that was just my career choice from very early on." He enjoys his profession and has become a strong supporter of patient advocacy: "Organized medicine has a multi-faceted role: first, as a patient advocate to monitor and develop the quality of care delivered," he says. "Another major role is to be the voice and advocate of its membership."

Dr. Lehman says that the Society should assume leadership in the health care arena, especially to develop its strength and influence among other provider groups. "We should be bold enough and strong enough to become *the* consultant group for health care issues in the legislative process." He cites recent government and the insurance industry actions as major forces behind key challenges facing medicine today. Important among these challenges to physicians are the high cost of and access to health care, according to Dr. Lehman. As a trustee, he is interested in the Society "working with government and policymakers to come up with some creative solution [to the problem] in terms of being fiscally responsible...and solving some access to care issues."

But even with all the problems, Dr. Lehman says, "The health care system in this country is second to none in the world despite all the rhetoric you hear." He finds benefits to a system, such as the Oregon plan which prioritizes care, and supports changes to insurance plans: "We need to look at deductibles and co-payments as ways to cut health care costs."

No matter what direction health care takes in this country, physician participation helps make the voice of organized medicine strong. That participation and strength make solutions possible, in the short and long terms, according to Dr. Lehman. "Organized medicine—with the difficulties it may have or perhaps the inability to accomplish what many practitioners feel it should—is still the best system around. It is much better to work *through* organized medicine than to try to do things on your own."

The civic leader

Not everyone begins a career in aerospace engineering, moves on to anesthesiology, runs rescue missions in the U.S. Navy, and has worked with C. Everett Koop, MD. Joining the State Society's Board of Trustees with those credentials is Edward N. Dench Jr., MD., of the Sixth District.

Dr. Dench, an anesthesiologist at Centre Community Hospital in State College, received his B.S. in aerospace engineering from Penn State. His interest in research/

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John W. Lehman, MD



Edward N. Dench Jr., MD



Richard J. Greco, MD

clinical work drew him toward his career switch, and he completed a medical degree specializing in anesthesiology at the University of Pennsylvania.

It was during his residency at Children's Hospital at Penn that Dr. Dench gave anesthesia for C. Everett Koop, MD, an experience he cites as one of the most exciting of his career. He also calls his work on rescue missions as a Naval flight surgeon "exciting," but finds the real challenge to be the "cognitive part" of his specialty. "Most people only think of the technical aspects of anesthesiology, but the real challenge," he says, "is where you are thinking and deciding what to do."

One interest that has remained constant throughout Dr. Dench's education and career is his involvement in the political process. His political career, which began when he served on the Undergraduate Student Government Senate at Penn State, includes serving in a number of local government positions and heading several political campaigns.

"I was involved in public politics long before organized medicine." In the early '80s, however, he became concerned about medicine. He realized that "unless doctors got more attuned to real politics, we were going to have a major problem," he says. "Politics were going to dictate the future of medicine, and without [physician involvement], there would not be good quality care." As an introduction to organized medicine, he served as an alternate delegate from his hospital to the AMA-HMSS.

The list of positions he has held since then within organized medicine is extensive, including: immediate past president of Centre County Medical Society, at-large member of the HMSS Council of the AMA, delegate from the HMSS to the State Society's House of Delegates, and president of the Pennsylvania Society of Anesthesiologists. Dr. Dench has also been an active participant of the Pennsylvania Medical Society's Federal Key Contact program since May 1989. In fact, he cites grassroots support as a crucial element for success in political battles.

Being elected to the State Society's Board of Trustees was his next logical step: "My biggest concern is maintaining the professional ethics of our profession...as well as serving the Society as best as I can." He says, "I have never pursued a position I was not sincere about or interested in...and I am very *sincere* about this."

The teacher

Like Dr. Dench, Young Physician Trustee Richard J. Greco, MD, began his political career in school. At Thomas Jefferson University, he became involved with the American Medical Student Association (AMSA), for which he served as president of the chapter and delegate to the national AMSA convention.

As a third-year medical student, Dr. Greco helped organize the Jefferson Chapter of the AMA and served as one of the original members of the governing council for the Pennsylvania Medical Student Section. That experience gave him the opportunity to attend several regional, state, and national conventions of organized medicine, where he became "very interested in how government was trying to impact medicine."

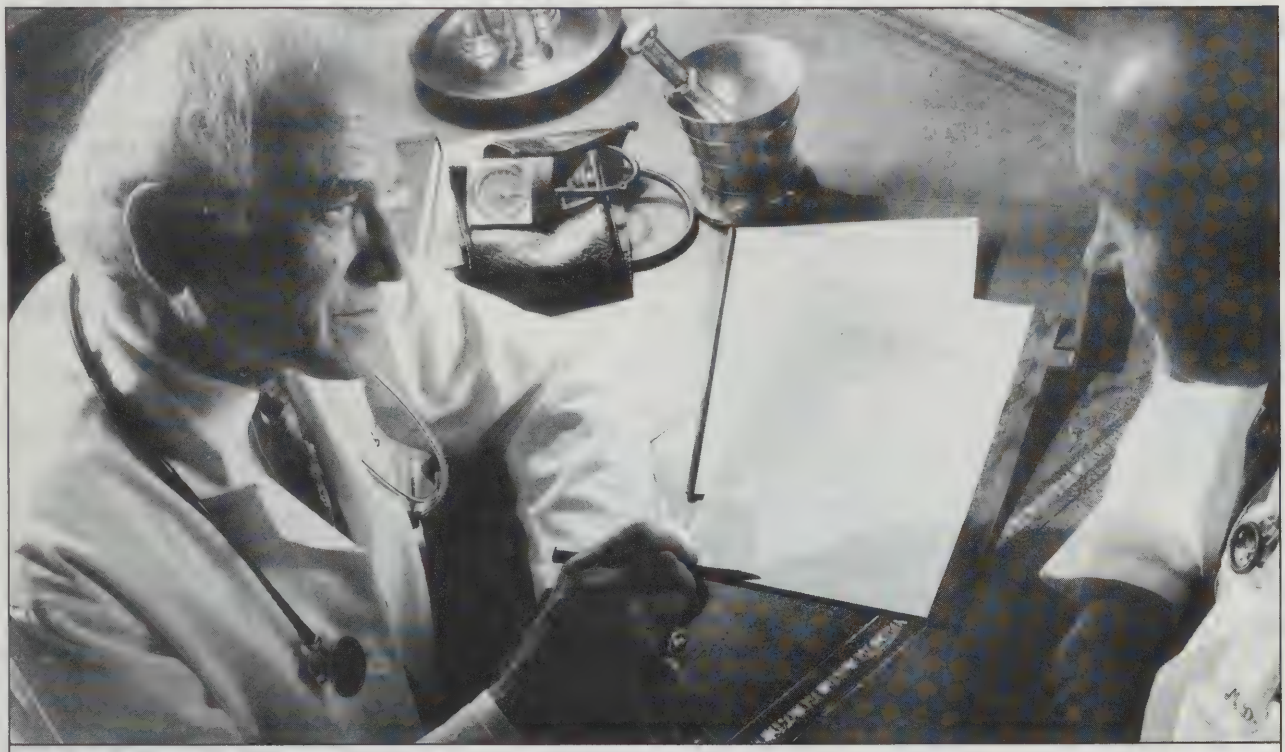
Dr. Greco is the fifth of six children of two State Society leaders. His father, Victor F. Greco, MD, serves as a trustee from the Twelfth District, and his mother, Jean Greco, is president of the Auxiliary. He trained in plastic and reconstructive surgery at the University of Pittsburgh, where he now teaches, and received his aesthetic surgery training at Manhattan Eye and Ear. He was also the recipient of a Hand Fellowship at the Hand Center in Philadelphia.

As a surgeon, Dr. Greco is affiliated with several hospitals in the Pittsburgh area including Presbyterian Hospital, Children's Hospital, McGee Women's Hospital, the VA in Oakland, and Montefiero University Hospital. Yet, his true love is teaching. "I stayed in academic medicine because I really enjoy the thrill of teaching young minds."

Still, involvement in organized medicine remains a priority for him. He cites the government's involvement with and possible banning of breast implants as one of the triggers of his personal involvement in organized medicine: "All specialties have specialized problems ...and as a society, we help decide what is safe and what is not safe."

"Part of my joining and staying involved in the Young Physician Section [is because] it is important for all physicians, especially young physicians, to be involved in organized medicine." He adds, "The changes that occur now will change the practice of young physicians for our entire careers...and one of my goals will be to get more young physicians involved because we have the most to gain from being involved."

When talking about teaching, Dr. Greco talks of "helping to shape the pathway" of his students. Referring back to that statement, he stresses physician involvement in organized medicine to "help shape *our own* pathway."



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Actions of the Board of Trustees, January 8, 1992

INFORMING MEMBERS ABOUT RBRVS IS PRIORITY

The State Society's Board of Trustees approved funds to expand the Society's RBRVS communications plan, set up to inform members of the impact of the new fee schedule. In 1992 the Society will use funds for member communications, publications, and physician services, including the January regional meetings. In related business, the Board directed Society staff to gather information from specialists and all Pennsylvania physicians for recommended improvements to the RBRVS fee schedule.

STEP TO ALTER AUTO LAW APPROVED

A recommendation of the Interspecialty Section relating to Act 6, the Auto Insurance Reform Act, was approved by the Board of Trustees.

Currently, Act 6 reimburses at a higher level when acute care is provided to a patient with a life-threatening or urgent injury in facilities accredited by the Pennsylvania Trauma Systems Foundation (PTSF). The recommendation directs the Society to seek amendments to the Act that would assure equal payment of trauma services regardless of PTSF accreditation status.

WORKERS' COMP ACTION PLAN IN MOTION

The Board approved as amended a strategic work plan presented by the Society's Workers' Compensation Quick Response Committee. The plan, already being implemented, seeks to promote the Society's alternative legislation plan by targeting audiences for specific messages. Elements include: face-to-face meetings, president's letters, publications, and informational pieces for the General Assembly.

BOARD FAVORS REDISTRICTING AND SUNSET OF ACT 89

The Board will support a by-laws change at the 1992 House of Delegates annual meeting to create a Thirteenth District of the State Society. The new district would consist of Allegheny County, and the Tenth District would change to include Beaver, Lawrence, and Westmoreland Counties. In the past two years, the House has looked at other plans for redistricting and has referred them back to the Board.

Also the Board of Trustees rejected a recommendation to support an amended version of Act 89 of 1986, the Health Care Cost Containment Act. Instead the Board voted to maintain its position that Act 89 should be sunset.

SOCIETY TO SEEK DPW TRAINING FUNDS

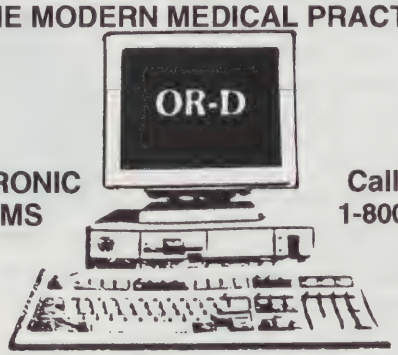
During meetings with the Society, the Department of Public Welfare (DPW) has said funds are needed to properly train providers' office staff about Medical Assistance (MA) billing. Though funds were included in previous DPW budgets, the state administration eliminated them during the budget process.

To try to remedy this problem, the Board approved a recommendation that the Society: 1) encourage DPW to continue requesting funds, and 2) lobby for inclusion of the funds in the Commonwealth's final budget.

SOCIETY TO INVESTIGATE GROUP MEMBERSHIP RATES

The Board of Trustees directed the Council on Membership to investigate the feasibility of the Society offering group membership rates. Considering the growing number of groups requesting such a plan, the trustees emphasized the importance of the proposal to investigate such incentives. The Society will seek AMA support.

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THE NEW OCCUPATIONAL EXPOSURE RULES: CRITICAL TO PHYSICIANS

On December 6, 1991, the Occupational Safety and Health Administration (OSHA) issued final regulations on occupational exposure to bloodborne pathogens. These regulations apply to all occupational exposure to blood or other potentially infectious materials in *all* medical settings and are critical for physicians. The following summary was taken in part from a report by the State Society's Council on Education and Science.

Exposure control plan

The regulations require physicians and other employers to create an exposure control plan, which must be: 1) in written form; 2) available to all employees; 3) updated annually or as required by changes in procedures, new equipment, etc; and 4) available to OSHA upon request. Several elements are required in the plan, including an exposure determination, methods of compliance, communication of hazards to employees, and record-keeping.

Exposure determination

The exposure determination is the consideration of which jobs include potential exposure to infectious materials as part of the normal routine. The employer must list all jobs which bear potential for exposure, and the procedures and tasks which employees will perform which place them at risk for exposure to infectious materials. When developing the exposure determination, the employer should disregard the use of personal protective equipment for tasks; even if the use of equipment drastically reduces the chances of exposure, the task *must* be listed.

Methods of compliance

The OSHA regulations make universal precautions mandatory, and all employers must ensure that employees are religiously practicing them. The regulations outline how engineering and work practice controls should be used to reduce the chances of occupational transmission of infectious disease.

Various controls are used to reduce exposure. For example, equipment must be examined and maintained or replaced on a regular schedule to ensure its effectiveness in reducing exposure. Also, mandated work practice controls are used, such as proper hand washing and disposal or labeling of sharp objects, including needles; and other "common sense" procedures are listed within work practice controls.

The regulations specify how to package infectious materials including sharps in leak-proof containers properly labeled for collection, handling, processing, storage, transport, or shipping. The regulations also apply to contaminated equipment and include the use of biohazard labels.

Personal protective equipment includes gloves, gowns, laboratory coats, face shields or masks, eye protection, mouth pieces, resuscitation bags, pocket masks, etc. The equipment is considered appropriate if it prevents blood or other infectious materials from passing through to the employee's street clothing or body. Physicians and other employers should be aware that these regulations mandate the provision of the equipment at no cost to employees.

Employers must require employees to use the protective equipment unless the employee declines because, in his/her professional judgment, it would prevent the delivery of health care or public safety services, or would pose an increased hazard to worker/co-worker safety. Such cases must be carefully documented.

The employer is also responsible: 1) to assure that all personal protective equipment is in proper sizes, clean, and laundered or discarded if disposable; 2) to repair and replace any equipment which is no longer effective; and 3) to implement good housekeeping procedures.

Hepatitis B vaccinations

Employers must make hepatitis B vaccinations available at no cost to all employees who risk occupational exposure. The vaccination must be made available after the employee has received required training in preventing occupational exposure to infectious diseases and within 10 working days of initial assignment to a job which carries the risk of occupational exposure. The only exceptions are for employees who have either previously received the complete vaccination series, demonstrated through antibody testing that they are immune, or proved the vaccine is contraindicated for medical reasons.

Employees may decline the vaccination, but the employer must obtain written verification of refusal. Specific language for the refusal is included in the regulations. Employers should note that if employees who decline the vaccination later change their minds, the employer is still responsible for its provision.

Post-exposure evaluation, follow up

Methods for dealing with post-exposure evaluation and follow-up are required and become applicable when an employee reports exposure. Under such circumstances, the employer must immediately make a confidential medical evaluation and follow up available to the exposed employee.

The evaluation and follow-up must include documentation of the routes of exposure, the circumstances under which exposure occurred, and the source individual, unless prohibited by law. The source individual's blood should also be tested, after obtaining consent, to determine HBV or HIV infection. Physicians should note that Pennsylvania law allows testing of a source patient's blood for HIV infection without consent as long as procedures outlined in the law are followed. The employee's blood should then be collected and, if the employee declines to be tested for HIV or HBV, the blood must be kept for 90 days in case the employee changes his/her mind during that period.

The employer is responsible for obtaining the evaluation of a health care professional, and for maintaining and reporting vaccination and exposure information about the employee to the professional. The employer must then provide a written copy of that health care professional's opinion to the employee within 15 days of completion of the evaluation. The post-exposure evaluation and follow-up report should be limited to the fact that the employee has been informed of the results of the evaluation and any medical conditions resulting from the exposure.

Communication of hazards to employees

The regulations outline how to

communicate hazards to employees, including labeling and packaging potentially infectious materials, and providing training to all employees at risk to occupational exposure. The training must be provided at no cost to employees during work hours and repeated annually. Additional training is required when tasks or procedures are modified, or new tasks or procedures affecting the employee's potential for exposure are implemented. Specific guidelines are outlined in the regulations.

Record keeping

Employers are required to establish procedures for maintaining accurate records for each employee with occupational exposure. All pertinent information—the employee's training program, hepatitis vaccination status, copies of all results of examinations, medical testing and follow-up, the employer's copy of a health care professional's written opinions, and copies of all information provided to the health care professional who provided the opinion—must be contained within the record. The records must be kept confidential except for reporting required by law, and maintained for at least the duration of the employee's employment plus 30 years.

Effective dates

The regulations as a whole become effective March 6, 1992. Employers are required to complete their exposure control plans on or before May 5, 1992; and the requirements of information, training, and record keeping take effect on or before June 4, 1992. All other requirements take effect July 6, 1992.

Many of the regulations are common sense and include universal precautions practiced by health care professionals for years. However, the regulations are extensive and fairly specific, and the creation of documents such as the infection control plan will create additional burdens for physicians. Physicians must remember that the regulations are now final and mandatory, and not open to debate.

The Society urges physicians to review the complete regulations for more detailed information. Noncompliance could endanger employees and lead to severe penalties, ranging up to $70,000 per incident. For additional information or a copy of the complete regulations, contact the Society's Council on Education and Science at 1-800-228-7823.

"INFECTIOUS DISEASES IN EVERYDAY MEDICINE - 2ND ANNUAL SYMPOSIUM"

This symposium will update the clinician on serious infections masquerading as more trivial problems, advances in understanding of HIV infection, and the status of new diseases, epidemics, and therapies. A syllabus will be provided.

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MRS. EUNICE KATZ
DIVISION OF INFECTIOUS DISEASES
UNIVERSITY OF MARYLAND SCHOOL OF MEDICINE
10 S. PINE ST.
BALTIMORE, MD 21201
(410) 328-7560 FAX (410) 328-8700

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Update Your Medicine Eighteenth Annual practical CME Course with Hands-on Workshops. Sponsored by the New York City Cornell University Medical College and the Association of Practicing Physicians of the New York Hospital. Category I credit. Information: Lila A. Wallis, MD, Director, and Debora A. Laan, Coordinator/445 East 69th Street, Olin 328, New York, NY 10021. Telephone: 212-746-4752.

JUNE 8-12TH, 1992

LEADERSHIP CONFERENCE: SURVIVAL ON THE HIGHWIRE

Pressures on physicians to perform have traditionally been high in the medical arena. Now outside forces attempting to control the economics of the practice of medicine often leave physicians feeling like they're walking the circus highwire. As government and consumer groups "shake the wire" with increasing regulations and demands, the cost of falling into the liability insurance/litigation net continues to rise. These factors—and many more—make survival of the practice of medicine a sideshow of its own.

This year's State Society Leadership Conference, "Survival on the Highwire," will address a wide range of issues which often cause physicians to "wobble" in their economic viability and medical authority. The annual conference on April 14-15, 1992, at the Hershey Lodge and Convention Center, will feature nationally known speakers on practice parameters, managed care, medical ethics, peer review, and other topics.

Robert E. McAfee, MD, vice chairman of the AMA Board of Trustees, will take center ring with a keynote presentation on practice parameters. He will be followed by Lucian Leape, MD, a lecturer at the Harvard School of Public Health and Tufts University School of Medicine, who will speak on liability reform.



Dr. McAfee

The remainder of the first day will be devoted to a panel discussion, "Can Quality Medicine Survive in a Managed Care Environment?" moderated by health law attorney Alice Gosfield, Esq., of Philadelphia. The panel includes: Neil Schlackman, MD, medical director for U.S. Healthcare; Michael A. Hattwick, MD, a practicing physician from Annandale, Virginia; and David B. Nash, MD, director of health policy and clinical outcomes at Thomas Jefferson University Hospital and Jefferson Medical College.

First in the ring on the second day is Monsignor Andrew J. McGowen, director of community relations at Mercy Hospital in Scranton, to speak on ethical issues affecting medicine. Eleanor Clift, *Newsweek* correspondent, and Fred Barnes, *New Republic* writer, will play tug-of-war with the highwire during a political point-counterpoint discussion.



Mr. Barnes

The Leadership Conference will wrap up with a series of workshops. Nicholas P. Constantakis, partner-in-charge of Arthur Anderson Healthcare Services in Pittsburgh, will present findings of the American College of Health Care Executives' Delphi Study conducted by Arthur Anderson. Michael Sheehan, a communications consultant based in Washington, DC, will lead "Presentation Skills and Image Building"; and Donald Harrop, MD, president of the Keystone Peer Review Organization (KePRO), will lead "Coping with KePRO." Three additional workshops are slated to address the topics of practical political involvement for physicians, stress management, and leadership for women physicians. The latter is sponsored by the Institute for Physician Leadership.



Mr. Constantakis

For additional information about the Leadership Conference, contact the State Society at 1-800-228-7823.

AMA DELEGATES TACKLE "HOT" ISSUES

Physicians across the U.S. are fighting battles similar to those faced by Pennsylvania physicians. This was readily apparent at the December 1991 interim meeting of the AMA House of Delegates, where Medicare payment reform (implemented on January 1, 1992), AIDS testing issues, and several other familiar "hot" topics were discussed.

Medicare payment reform

Hours of debate at the interim meeting reflected the anger many physicians feel about the new Medicare reform. Yet, delegates opposed several suggestions during the meeting designed to halt the new Medicare payment system. Instead, they agreed not to endorse the new system until substantial improvements are made. Adopted recommendations for the AMA are detailed in "Understanding the New Medicare Fee Schedule" (see page 10).

AIDS testing issues

Newspapers across the state and the country reported that AMA delegates debated several measures relating to HIV infection and AIDS. One measure called for abandonment of the idea of developing an "AIDS Risk List"—a list of procedures health care workers should not perform if they are infected with HIV. Instead, the House adopted an AMA Board of Trustees report calling for voluntary testing for physicians who perform certain exposure-prone procedures and for supervision of physicians who are infected with HIV.

The AMA adopted measures for universal precautions, insurance options, confidentiality for patients, education of patients, and further research on reducing transmission risks, and reaffirmed its opposition to mandatory testing and reporting of physicians. The House also approved a measure which states that physicians should be able to perform HIV testing without consent on patients suspected of being infected.

Self-referral guidelines

Prompted by concerns over potential conflicts of interest, the AMA says physicians should not refer patients to facilities in which they have large investments. An adopted report outlines exceptions related to quality care issues.

Resident work hours

The Governing Council of the AMA Resident Physicians Section agreed to a compromise regarding resident work hours. The compromise, developed by section leaders and representatives of the Residency Review Committee for Surgery, leaves the work hour decision in the hands of surgeons. However, according to AMA sources, the report states that "it is 'desirable' for surgery training programs to allow overnight call no more than once every third night and to permit one day off duty each week." The compromise may conclude the five-year debate on the issue.

Health Access America
Increased political and public interest in national health care reform has prompted the AMA to refine and strengthen its health reform plan, first released in March 1990. The plan, Health Access America, calls for comprehensive reform on several levels, including in the workplace and within the Medicaid system. The plan was endorsed with only minor revisions.

National Practitioner Data Bank
Continued frustration and confusion among physicians were obvious this year as the delegates voted to seek abolishment of the data bank, in operation for less than two years. Physicians are concerned about inadequate confidentiality safeguards of information in the bank. According to AMA trustees, the action will not halt efforts to modify the bank's operation, but if modification does not work, the AMA will then seek abolishment of the bank.

YPS action
The AMA Young Physicians Section (YPS) debated HIV testing, sexual harassment, interpersonal violence education, and abortion. Highlighting the debate, however, was Medicare payment limits on physicians in the first four years of practice (see "New Physician Reductions Under Medicare" on page 13). The YPS was instrumental in engaging AMA support to repeal the limits.

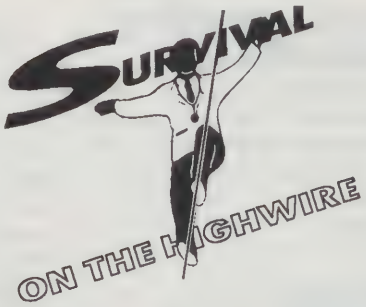
Pennsylvania resolutions
Seven of the nine resolutions submitted to the AMA House of Delegates by the Pennsylvania delegation were adopted during this year's interim meeting. These resolutions direct the AMA to:

- Respond to the report, "Manipulation of Procedure Codes by Physicians to Maximize Medicare and Medicaid Reimbursements," recently released by the Office of the Inspector General of the Department of Health and Human Services;
- Study several specific aspects of the new Medicare payment system related to the RBRVS conversion factor and fully licensed versus limited licensed practitioners (see "RBRVS Covers Limited Licensed Practitioners" on page 16);
- Continue to monitor the study of small area analysis; and
- Urge HFCA to publish in the *Federal Register* for review and comment any significant proposed changes in the peer review organization (PRO) process or procedures which would affect physician practice patterns and/or the delivery of medical care.

Other resolutions addressed federal restrictions for long-term care, smoking cessation, federal regulation of antipsychotic drug use in nursing homes, and AMA representation.

Pennsylvania officers
Officers of the State Society's AMA Delegation elected at the interim meeting are: Howard A. Richter, MD, Wynnewood, chairman; Donald H. Smith, MD, Easton, vice chairman; Michael J. Prendergast, MD, York, secretary; Victor F. Greco, MD, Drums, delegate-at-large; and Joseph A.C. Girone, MD, Sellersville, alternate delegate-at-large.

Quality, cost, access — a delicate balance.



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The Pennsylvania Medical Society

April 14-15

Hershey Lodge and Convention Center, Hershey

Featuring:

- "Can Quality Medicine Survive in a Managed Care Environment?" with panelists Alice Gosfield, Esq.; Neil Schlackman, MD, Medical Director, U.S. Healthcare; Michael A. Hattwick, MD; David B. Nash, MD, Jefferson Medical College;
- "Health Care: Election '92" with *Newsweek*'s Eleanor Clift and *The New Republic*'s Fred Barnes;
- "Practical Political Involvement for Physicians";
- A workshop for the future leaders of medicine;
- "Coping with KePRO," with Donald Harrop, MD, President, Keystone Peer Review Organization;
- "Practice Parameters," with Robert E. McAfee, MD, Vice Chairman of the AMA Board of Trustees;
- "Liability Reform," with Lucian Leape, MD, Harvard;
- *Pittsburgh Press* political cartoonist Rob Rogers.

The Pennsylvania Medical Society is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians.

Watch for registration information in the next issue of Executive Report.

Call (717) 558-7750 for more information.

The Pennsylvania Medical Society designates this continuing medical education activity for 7 1/2 credit hours in Category 1 of the Physicians Recognition Award of the American Medical Association and the Pennsylvania Medical Society membership requirement.

BURKHOLDER INAUGURATED 127TH ACMS PRESIDENT

John A. Burkholder, MD, was inaugurated as the 127th president of the Allegheny County Medical Society (ACMS) at the annual installation of officers on January 17, 1992. He succeeds Stanley M. Marks, MD.

Dr. Burkholder, a thoracic surgeon, practices at Allegheny General Hospital and is affiliated with the Health Center Hospitals of the University of Pittsburgh and St. Francis General Hospital. He also serves as associate professor of surgery at the Medical College of Pennsylvania and is a clinical assistant professor of surgery at the University of Pittsburgh.



Dr. Burkholder

He joined ACMS in 1971 and has held several leadership positions since 1972, when he was named to the Environmental Problems Committee. Since that time, he has also been active in the State Society, the AMA, and several specialty societies.

Dr. Burkholder received his medical degree from Johns Hopkins University and completed his surgical and cardiac surgery residencies at the Health Center Hospitals of the University of Pittsburgh.

Other ACMS officers installed are: George J. Gerneth, MD, an ophthalmologist affiliated with Eye & Ear, Braddock, and St. Francis Hospital, as president-elect; Lee H. McCormick, MD, a family practice specialist affiliated with Jefferson Hospital and Braddock Medical Center, as vice president; and Nancy S. Nieland, MD, a dermatologist and clinical assistant professor of medicine at the University of Pittsburgh School of Medicine, as secretary. John S. Oehrle, MD, a pathologist and hemotologist at Allegheny Valley Hospital, will serve a fourth term as ACMS treasurer.



Dr. McCormick

Each year, as part of the inauguration dinner, ACMS honors county leaders for outstanding contributions to organized medicine and the community. Morry Shapiro, MD, a specialist in internal, pulmonary, and occupational medicine at Braddock General Hospital, was honored with the Nathaniel Bedford Award for his lifelong dedication to patient care. Ralph Gaudio, MD, specialist in internal medicine and pulmonary disease, received the Frederick M. Jacob Physician's Merit Award for his outstanding contribution to ACMS.

Two Benjamin Rush Awards were also presented. Ursuline Center, Inc. (UCI), a non-denominational, non-profit human service agency, received the Organization Award for its Senior Adult Services Program. Margaret (Nina) Ciccozzi, a member of the oncology health care team at Sewickley Valley Hospital, received the Individual Award for her devotion to and compassion for patients.

SOCIETY RELEASES POLL FINDINGS

The State Society has released the findings of the 1991 Membership/Leadership Poll conducted by The Educational and Scientific Trust in August 1991. The poll, last taken in 1989, sought to discover how members and leaders view specific medical and public health issues. Physicians' opinions were then compared with Gallup Poll public opinion of specific health care issues. The following is an overview of issues addressed.

Health Issues

Regulations, government control, and third-party reimbursement are the main problems facing health care and medicine in Pennsylvania today, according to physician responses in the final report. That differs from public opinion, in which one-third of Pennsylvanians feel the high cost of health care, including medical care and the cost of insurance, is the dominant problem.

Practice issues

Survey recipients were asked to rank, from a given list, the three most important issues affecting the practice of medicine in Pennsylvania that the State Society should address. Approximately 75 percent of members agreed that outside regulation of the practice of medicine was number one, followed by Medicare reimbursement issues and medical malpractice litigation. Public opinion indicated a concern for access and indigent care issues.

Public health/affairs issues

Respondents were asked to rank, from a given list, the top three public health and affairs issues the Society should address. A majority (78.6 percent) of respondents ranked health care costs as one of the top three issues. Access to health care, substance abuse, and HIV testing also received majority votes.

The membership poll included two questions about AIDS testing issues. First, when asked if there should be mandatory *patient* testing for HIV, 38.8 percent of physicians said "yes," 21.9 percent said "no," and 37.9 percent said "only in certain circumstances." Second, when asked what type of HIV testing there should be *for physicians*, approximately 30 percent of the membership replied, "Only for physicians performing invasive procedures"; and an equal percent responded, "Only for physicians in high-risk groups." Twenty percent replied that physicians should receive mandatory testing on a regular basis.

An additional public health issue Gallup Poll respondents were asked about by the Society was the role physicians play in fighting substance abuse. Fifty-four percent perceived physicians as either "leading the fight" or "visibly involved in the fight" against substance abuse. Look for additional information about the Society's Membership/Leadership Poll in future issues of PENNSYLVANIA MEDICINE.

ORTHOPEDIC SOCIETY MEETING SCHEDULED

The Pennsylvania Orthopedic Society will hold its spring meeting, April 30-May 2, 1992, at the Registry Resort in Naples, Florida. The program, "The Knee: Pediatrics to the Senior Citizen," will feature the following guest speakers: Jay S. Cox, MD; Kenneth A. Krackow, MD; Lyle J. Micheli, MD; Richard D. Parker, MD; and Kelly Vince, MD. For additional information, contact the Pennsylvania Orthopedic Society at P.O. Box 8820, Harrisburg, PA 17105-8820, 1-800-228-7823.

AARP SURVEY RESULTS STRESS COOPERATION

Extended cooperation and better communication are needed between aging, social service, and medical communities. According to a survey released in December 1991 by the American Association of Retired Persons (AARP), when those two goals are achieved, the communities will be able to provide more complete information to consumers and each other about the options and issues of long-term care.

AARP conducted the two-year research initiative to learn more about information needs relevant to long-term care and how best to respond to those needs. The consumer survey found "that many consumers in search of long-term care information don't know where to find information and know relatively little about the resources that might be available to them."

Physicians and long-term care facilities were found to be the most common sources of long-term care information for consumers.

EICHELBERGER TO KEYNOTE ATS CONFERENCE

Martin Eichelberger, MD, director of trauma at Children's National Medical Center and president of the "Safe Kids" Coalition, is slated to speak at the sixth annual conference of the American Trauma Society (ATS), Pennsylvania Division. The conference is scheduled for April 9-10, 1992, at the Hershey Lodge and Convention Center in Hershey.

Session topics will include: societal violence, insurance reimbursement in trauma, dealing with death, families and organ donation, management of the head-injured patient, the ethics of trauma care, violence in the emergency department, and the many faces of pediatric trauma. For more information about the conference and fees, call the ATS Pennsylvania Division at (717) 766-1616.

CORRECTION

The State Society's Task Force on Aging regrets the omission of the following Geriatric Assessment Centers inadvertently omitted from the *Physicians Resource Guide: Caring for the Elderly*, which was included as an insert in the November 1991 issue of PENNSYLVANIA MEDICINE.

York Hospital Geriatric Assessment Center
Apple Hill Medical Center
25 Monument Road
York, PA 17403
(717) 741-8235

Mifflin-Juniata Area Agency on Aging, Inc.
Geriatric Assessment Program
3 Monument Square
Lewistown, PA 17044
(717) 242-3683

AGES (Ambulatory Geriatric Evaluation Service)
Allentown Hospital-Lehigh Valley Hospital System
Suite 1500,
1243 South Cedar Crest Boulevard
Allentown, PA 18103
(215) 778-9890

HEADACHE
IN THE DECADE OF THE BRAIN

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*The Seventh Headache Symposium presented by The Comprehensive Headache Center at The Germantown Hospital and Medical Center and *Temple University School of Medicine*

On July 25, 1989 President George Bush signed into law H.J. Res. 174 declaring the 1990's "The Decade of The Brain." Its passage signals a new age of research surrounding disorders of the brain. Please join us and our panel of international experts to explore some of the topics that will shape the decade.

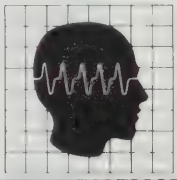
Our faculty will include:

Neil Raskin, M.D.
University of California, San Francisco

Michel Ferrari, M.D.
University Hospital, Leiden, Netherlands

Steven B. Graff-Radford, D.D.S.
Cedars - Sinai Medical Ctr., Los Angeles, CA

Stephen D. Silberstein, M.D.
The Germantown Hospital & Medical Center



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** Temple University School of Medicine is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor Continuing Education for physicians.*

Temple University School of Medicine designates this CME activity for 6 credit hours in Category 1 of the Physicians' Recognition Award of the A.M.A.

Symposium funding provided by GLAXO, Inc.

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When Your Patient Declares Bankruptcy

With tough economic times continuing, more of your patients may file for bankruptcy; and if the bankrupt patient has an outstanding bill, your practice will be directly affected.

Bankruptcy means that: 1) creditors must cease collection action, and 2) most debts are "discharged" (considered paid-in-full after the proceeding). Debtors pay a price for this protection. Typically assets must be used to pay creditors, and certainly financial records are tarnished. Nevertheless, bankruptcy has lost much of its stigma. It is inexpensive and simple to file, and today lawyers specialize in consumer bankruptcy. Also, the law prohibits hiring discrimination based on a past bankruptcy.

While there are several types of bankruptcy, patients will usually be protected under either "Chapter 7" or "Chapter 13." Here's how to handle those debtor-patients.

1. *Verify the bankruptcy:* As part of the filing of a petition of bankruptcy, the debtor must identify all creditors. Within a few days, the court mails notice of the bankruptcy to the creditors. There is no reason for the debtor to omit creditors, since only listed debts are discharged.

But don't take the patient's word for a filing. If a court notice hasn't been received, verify the filing. Ask for the name, address, and phone number of the patient's attorney, and call to make sure copies of all court papers will be received. The patient's attorney may be contacted periodically, but since these are low-fee cases, physicians are unlikely to receive much information.

2. *Stop collection action:* There are penalties for pursuing collection action after notice of bankruptcy. Mark the file so that collection stops—including phone calls, letters, or use of an agency. If the account is with an agency, notify them to stop processing it and return the file.

3. *File a claim:* Consult the practice's attorney to assure that everything necessary is completed to protect right to payment. A Proof of Claim may need to be filed with the court, supplying the amount of and basis for the patient's debt (i.e., the bill). In most districts, the court clerk will mail the form directly to the physician.

There is not much else for the practice to do during the bankruptcy proceeding. A meeting of creditors is held, but usually physicians need not attend, unless there is an objection to the bankruptcy. In a Chapter 13 filing, creditors must vote on a repayment plan. Typically there is nothing to object to, from the viewpoint of "small" creditors. Consult the practice's lawyer, however, if anything appears out-of-the-ordinary.

4. *Don't expect much:* Usually, an "unsecured creditor," such as a physician, can expect to be paid no more than pennies for each dollar.

In Chapter 7, the more common consumer filing, payment of 8 to 10 cents per dollar owed is typical. Chapter 7 requires liquidation of most of the debtor's assets. The debtor keeps post-filing income as a fresh start. Chapter 7 debtors typically have insignificant assets and little income. To minimize payments to creditors, consumer bankruptcy lawyers often advise Chapter 7 debtors to spend all cash and other liquid assets prior to filing.

In a Chapter 13 bankruptcy, the debtor can keep any assets, but must use "disposable income" to pay debts in installments. Unsecured creditors usually receive more dollars under Chapter 13, but the value is reduced by the long wait for repayment—from three years minimum to five years maximum (as opposed to six months in Chapter 7).

In both Chapters 7 and 13, amounts owed to secured creditors (e.g., mortgage holders) and for taxes and administrative expenses (e.g., lawyers' fees), are deducted first, dollar-for-dollar, from available monies. Any remaining funds are then divvied up among unsecured creditors in proportion to the amounts owed to them. In either case, the payment from the bankruptcy—discharging the debt—is probably all the practice will get.

Be aware of two other technical points: first, if the patient paid a bill within 90 days of filing, the creditor may have to return the payment to the patient's trustee for redistribution among creditors. If a debtor's representative demands repayment of this "preference," consult an attorney.

Second, if the patient has an insurance-covered bill owing at the time of filing, the physician may be able to collect in full from the carrier, depending on the circumstances and coverage. Speak with the insurer, and consult an attorney if questions arise.

5. *Consider the future:* Bankruptcy only applies to existing debts. What if the patient asks for services in the future? Bankruptcy law doesn't prohibit requiring more security for payment, demanding payment at time of service, or refusing to deal with the patient. A physician should consult the practice attorney for assurance that such refusal doesn't constitute patient abandonment. Also, insurers' rules may require a physician to continue the relationship. Always consider the cause of bankruptcy. If the patient's problem is temporary (perhaps disability or a job layoff), a physician may want to create a very flexible payment plan or make other accommodations.

These fairly simple steps—verifying the filing, stopping collection action, and filing a claim—afford the best protection possible for a practice's interests in a patient's bankruptcy. In the long run, of course, the patient's goodwill toward the practice may be more valuable than the amount of the debt.

The contributing authors, Susan Gorn, JD, and Judith A. Mackarey, JD, are attorneys and consultants with The Health Care Group, a medical practice management consulting firm based in Plymouth Meeting.

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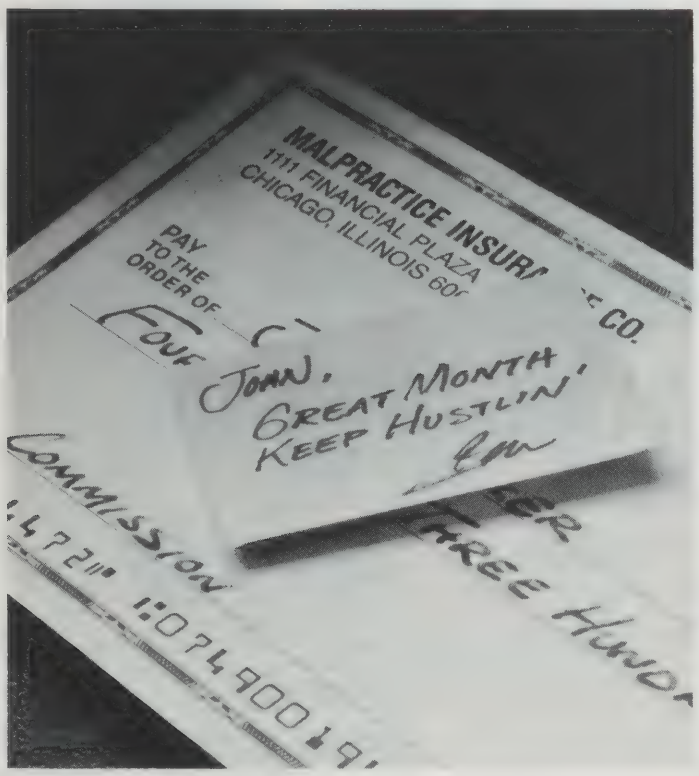
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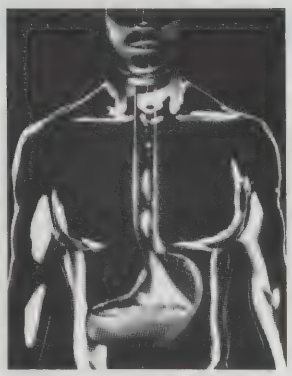
Of all the H_2-receptor antagonists, only Axid heals and relieves reflux esophagitis at its standard duodenal ulcer dosage. Axid, **150** mg b.i.d., relieves heartburn in **86%** of patients after one day and **93%** after one week.[1]

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1. Data on file, Lilly Research Laboratories. *See accompanying page for prescribing information.* ©1991, ELI LILLY AND COMPANY NZ-2947-B-249304

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Brief Summary. Consult the package insert for complete prescribing information.

Indications and Usage: 1. *Active duodenal ulcer*—for up to 8 weeks of treatment at a dosage of 300 mg h.s. or 150 mg b.i.d. Most patients heal within 4 weeks.

2. *Maintenance therapy*—for healed duodenal ulcer patients at a dosage of 150 mg h.s. at bedtime. The consequences of therapy with Axid for longer than 1 year are not known.

3. *Gastroesophageal reflux disease (GERD)*—for up to 12 weeks of treatment of endoscopically diagnosed esophagitis, including erosive and ulcerative esophagitis, and associated heartburn at a dosage of 150 mg b.i.d.

Contraindication: Known hypersensitivity to the drug. Because cross sensitivity in this class of compounds has been observed, H_2-receptor antagonists, including Axid, should not be administered to patients with a history of hypersensitivity to other H_2-receptor antagonists.

Precautions: *General*—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests—False-positive tests for urobilinogen with Multistix® may occur during therapy.

Drug Interactions—No interactions have been observed with theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility—A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups.The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Worldwide, controlled clinical trials included over 6,000 patients given nizatidine in studies of varying durations. Placebo-controlled trials in the United States and Canada included over 2,600 patients given nizatidine and over 1,700 given placebo. Among the adverse events in these placebo-controlled trials, only anemia (0.2% vs 0%) and urticaria (0.5% vs 0.1%) were significantly more common in the nizatidine group. Of the adverse events that occurred at a frequency of 1% or more, there was no statistically significant difference between Axid and placebo in the incidence of any of these events (see package insert for complete information).

A variety of less common events were also reported; it was not possible to determine whether these were caused by nizatidine.

Hepatic—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

CNS—Rare cases of reversible mental confusion have been reported.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of anti-androgenic activity due to nizatidine. Impotence and decreased libido were reported with similar frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic—Anemia was reported significantly more frequently in nizatidine than in placebo-treated patients. Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H_2-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental—Urticaria was reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity—As with other H_2-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. The ability of hemodialysis to remove nizatidine from the body has not been conclusively demonstrated; however, due to its large volume of distribution, nizatidine is not expected to be efficiently removed from the body by this method.

PV 2093 AMP [101591]

Additional information available to the profession on request.

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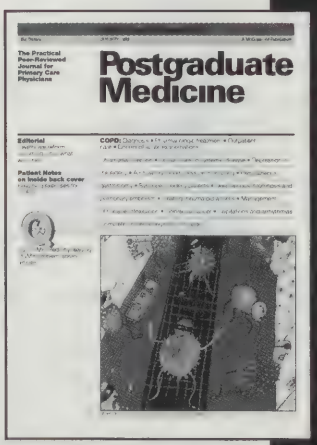
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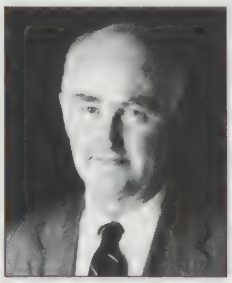


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Postgraduate Medicine

Gordon K. MacLeod, MD, immediate past-president of the State Society, has been appointed to serve on a subcommitee of the Board of Scientific Counselors of the National Cancer Institute.


Dr. MacLeod

John L. Melvin, MD, a noted specialist in physical medicine and rehabilitation (PM&R), has been named vice president for medical affairs of MossRehab, Inc., parent corporation of Moss Rehabilitation Hospital. Dr. Melvin has also been named chairman of the Department of Rehabilitation Medicine at Albert Einstein Medical Center and professor/deputy chairman of the Department of PM&R at Temple University School of Medicine.


Dr. Melvin

Jouni Uitto, MD, PhD, chairman and professor of dermatology at Thomas Jefferson University, served as senior author of a genetics study which identified the gene that binds skin. The results were published in several national medical journals in Fall 1991.

Perry Black, MD, chief of neurosurgery at Hahnemann University, was elected president of the Pennsylvania Neurosurgical Society.

Abraham J. Twerski, MD, founder and medical director of Gateway Rehabilitation Center, will receive in March the 1992 Joseph F. Mulach Jr. Award from the Vocational and Rehabilitation Center in Pittsburgh. The award is given annually to a person who has significantly improved the quality of life for people with disabilities.

Jerome M. Cotler, MD, was named the first Dr. Everett J. and Marian Gordon Professor of Orthopedic Surgery at Jefferson Medical College of Thomas Jefferson University.

Marguerite Bonaventura, MD, Pittsburgh, received a three-year appointment as cancer liaison physician for the Cancer Program at Western Pennsylvania Hospital.

Edwin C. Fischl, MD, general surgeon, was elected vice president of the Medical Bureau of Pittsburgh for 1992. **Peter J. Wargo, MD,** OB/GYN, was elected secretary.

James M. Herman, MD, was appointed chairman of the Department of Family and Community Medicine at Penn State's College of Medicine at The Milton S. Hershey Medical Center.

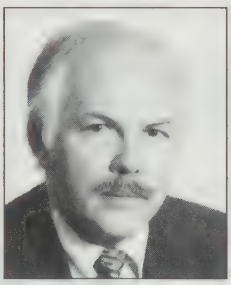
Roy L. Titchworth, MD, specialist in internal medicine and cardiopulmonary disease, was elected chairman of the Allegheny County Board of Health.

Jack A. Gomberg, MD, was appointed director of specialized adolescent services at Friends Hospital.

Yahya Fadl, MD, internal medicine and oncology specialist at Frick Medical Center, was elected to the board of directors of Fairmont Affiliates, Inc.

William H. Fee Jr., MD, internist and pulmonologist at Franklin Regional Medical Center, was named medical advisor to the board of directors of the American Heart Association.

John W. Hoyt, MD, head of critical care medicine at St. Francis Medical Center in Pittsburgh, has been selected for inclusion in an upcoming publication, *The Best Doctors in America*.


Dr. Hoyt

Mark R. Publicker, MD, a family practitioner in Pittsburgh, was appointed chairman of the United Way Task Force on Medication Management for the Elderly.

Gregory J. Salko, MD, was named president of the medical staff at Carbondale General Hospital.

Joyce Frye, DO, FACOG, was appointed chair of the Gynecology Department at Presbyterian Medical Center.

James B. Stephenson, MD, was appointed director of the Trauma Program at Brandywine Hospital.

Clara Jean Ersoz, MD, vice president of medical affairs at St. Clair Hospital, has co-authored a book entitled, *The Health Care Manager's Guide to Continuous Quality Improvement*.

Francis D. Beyer, MD, pathologist at Frick Medical Center, was elected to the board of directors of Frick Diversified Services Corporation.

Juan E. Grunwald, MD, was appointed to serve as a member of the National Institutes of Health's Visual Sciences C Study Section, Division of Research Grants, until June 1995. Dr. Grunwald is an associate professor of ophthalmology at the University of Pennsylvania and an ophthalmologist and research scientist at Penn's Scheie Eye Institute.


Dr. Grunwald

Macy I. Levine, MD, Pittsburgh allergist, spoke on the subject, "Insect Sting Allergy," before the Society of Basic and Clinical Allergy in Tokyo, Japan.

Jeffrey Malumed, MD, orthopedic surgeon at Taylor Hospital, will be the sole physician to accompany the men's U.S. ski team to Europe for two World Cup competitions.

R. Barrett Noone, MD, was named director of the Department of Surgery at Bryn Mawr Hospital.

Joel Safier, MD, will serve as president of the Pittsburgh Pediatric Society for the 1991-93 term. **Paul F. Dubner, MD,** will serve as program chairman.

Benjamin Krevsky, MD, will serve as principal investigator for a study at Temple University Hospital to research and determine the optimal therapy for esophageal cancer. Temple received a three-year, $478,000 grant from the National Cancer Institute of the National Institutes of Health in Washington, DC, to fund the project.

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Contemporary Issues in Internal Medicine
Wednesday, March 11, 1992

Advanced Trauma Life Support Provider Course (ATLS)
Friday & Saturday, March 13 & 14, 1992

Advances in Dermatology
Wednesday, April 1, 1992

Advanced Cardiac Life Support Renewal Course
Saturday, April 4, 1992

Update in Family Practice
Wednesday, April 8, 1992
Danville Days Inn

2nd Annual Focus on Sports Medicine
Saturday, April 11, 1992
Danville Days Inn

Controversies in the Management of Prostate Diseases
Wednesday, April 15, 1992

Pediatric Advanced Life Support Provider Course
Thursday, Friday, April 23 & 24, 1992

Airway Diseases
Wednesday, April 29, 1992

6th Annual Sight Loss Support Group Meeting
Wednesday, May 6, 1992
Danville Days Inn

Care of the Diabetic with the Dysvascular Foot
Wednesday, May 13, 1992

Update in Obstetrics & Gynecology
Wednesday, May 20, 1992
Danville Days Inn

6th Annual Symposium in Clinical Medicine
June 22-25, 1992
Hilton Head Island, SC

Please check each specific flyer as it arrives for starting time, location, number of credit hours, and types of credit. Programs may be cancelled due to insufficient registration. If not pre-registered, please call to confirm the program.

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As an organization accredited by the Pennsylvania Medical Society for its continuing medical education program, the Geisinger Clinic designates these activities as meeting the criteria for Category I credit for the American Medical Association's Physician's Recognition Award and the Pennsylvania Medical Society membership requirement. Please refer to each individual program flyer for registration fees, starting times, and number of credit hours. For further information or for copies of individual programs, call Sharon Hanley, RMP, collect, at 717-271-6692. There is a 24-hour answering service available. You may also write to her at North Academy Avenue, Danville, PA 17822-1350.

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ER physicians—Full-time/part-time positions available NJ, PA, NY. Emergency medicine experience preferred. Guaranteed compensation and paid malpractice. For more information call (215) 521-5100 (within PA), 1-800-TRAUMA6 (outside PA), or send CV to Trauma Service Group PC, Scott Plaza, Building Two, Suite 114, Philadelphia, PA 19113.

Western Pennsylvania—Board Certified or prepared emergency physicians needed for staffing a community hospital emergency department near the Ohio/Pennsylvania border. Please send CV to P.O. Box 99431, Pittsburgh, PA 15233-0431.

Pennsylvania—Physician group seeks full-time and part-time physicians for an emergency department of community hospitals in central and western Pennsylvania. Please send resume to P.O. Box 99431, Pittsburgh, PA 15233-0431.

General internist—Immediate opening available for dynamic BC/BE physician to join well-established internal medicine practice in southwestern Pennsylvania. Salary $100,000. Benefit package $10,000. Pension plans. Future partnership option. In-house laboratory and x-ray facilities. Excellent opportunity. Reply Box 345, PENNSYLVANIA MEDICINE, 777 East Park Dr., P.O. Box 8820, Harrisburg, PA 17105-8820.

Pocono Mts. area—Northeast Pennsylvania busy family practice looking for BE/BC family practitioner. No Ob; active hospital practice; partnership possibilities. Skiing, boating, hiking within 5 miles. 90 minutes from Manhattan and Philadelphia. Please send CV to: Monroe Family Practice Assoc., 1803 W. Main, Stroudsburg, PA 18360; (717) 421-0170.

Pennsylvania—Staff position available to BC/BP family oriented career emergency physician 22K ED visits/year. All ED physicians BC/BP in emergency medicine. 238-bed facility, excellent medical/nursing staff, strong community, many outdoor activities, easy urban access. Very competitive compensation package for 1752 hours, equitable matrix schedule. Contact: Jeffrey D. Raub, MD, FACEP, Director, DES, Franklin Regional Medical Center, 1 Spruce St., Franklin, PA 16323; (814) 437-7000 ext. 5220.

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PEDS, OB/GYN, IM, FP—Group practice opportunities, Philadelphia area, confidentiality protected. Contact Al Yannelli, Yannelli Randolph & Co., 994 Old Eagle School Rd., Ste. 1020, Wayne, PA 19087 (215) 964-1616.

Pittsburgh, Pennsylvania—Penn Group Medical Association (PGMA), a multi-specialty group practice affiliated with the largest HMO in Pittsburgh, is seeking BE/BC physician in: family practice, internal medicine, pediatrics, ob/gyn, and psychiatry. We are formally affiliated with major teaching hospitals and leading community hospitals in Pittsburgh. PGMA serves seven ambulatory care centers, all conveniently located near cultural, educational, recreational, and corporate activities. Excellent salary, fringe benefits, and incentives. For confidential consideration contact: Angela Lascola, HealthAmerica, 5 Gateway Center, Pittsburgh, PA 15222 or call collect (412) 553-7502.

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Emergency Department position. 30,000 visits/year. Growing comprehensive community hospital in north central Pennsylvania. Excellent reimbursement. Forward CVs to George A. Manchester, Medical Director's Office, Divine Providence Hospital, 1100 Grampian Blvd., Williamsport, PA 17701.

Community hospital based pathology group in south-central Pennsylvania needs locum tenens pathologist for coverage during vacations and meetings. Strong surgical pathology skills required. Good clinical pathology skills desirable. For the right person, potential for 18-20 weeks per year assignment. Reply to Box 368, PENNSYLVANIA MEDICINE, 777 East Park Dr., P.O. Box 8820, Harrisburg, PA 17105-8820.

Solo family practitioner seeks associate in busy practice. Partnership available in one year. Guaranteed salary. Rural community 30 miles northeast of Pittsburgh. Contact: Debra McFadden, MD, (412) 845-7765.

Emergency Department position. 11,000 visits/year. Small stable community hospital affiliated with larger hospital, north central Pennsylvania. Forward CVs to: Stan H. Swartz, MD, Muncy Valley Hospital, Emergency Department, 215 East Water St., Muncy, PA 17756.

Seeking associate for busy family practice in western Pennsylvania area. Salary and benefits negotiable with full partnership possibilities. Transportation and accommodations paid for meeting. Contact Chris at (412) 758-7524.

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AIR FORCE

Family Unity: A Point of View

Victor F. Greco, MD

"In life everything depends upon your point of view."

I don't have to remind you about what is happening in our society. I certainly don't like to quote statistics because we all know them very well, but there are a few that stick out in my mind which, perhaps, help us focus a bit. We know we are in the midst of a scourge called AIDS. In Pennsylvania alone, we have 4,800 reported cases of active AIDS and of these, about 3,200 have already died. We know that 65 percent of all children born in the United States are born of unwed mothers between the ages of 15 and 19. In Pennsylvania that figure is 78.5 percent. We also know that sexually transmitted disease is on the increase, and the divorce rate climbed from 50 percent to 67 percent. I find these statistics rather startling!

What is it that we in organized medicine are not addressing or doing correctly? Life is not simple, but there are reasons for these statistics. However, to sit back and wring our hands in emotion and cry to the heavens is not the answer; addressing family unity is.

Family unity is important because every great civilization that has fallen, has fallen because of a decline in the family unit. If you don't have a family unit, you don't have a community unit; and if you don't have a community unit, you don't have a state unit or a country. It all goes back to the family.

Where did we all go wrong? In trying to analyze this problem, we should start with our good friend and renowned educator, John Dewey. His philosophy of education was pragmatism: "If it isn't something that's going to be useful, don't teach it." We began to worship at the altar of mediocrity because we had to teach pragmatism. Those who were gifted and intelligent were made to feel as outcasts because they were not jocks. Intelligent bookworms were looked down on.

Then one of our colleagues came along by the name of Dr. Benjamin Spock and said, "We must allow our children to do what they want to do, and you must not discipline them...Do not spank, do not say no, let them do what they want to do." So we became pliant parents. We abrogated our responsibilities as parents from whom love should have been dispensed and from whom discipline, responsibilities, and obligations should have been taught. Thus we ended up with mediocre children who could do what they wanted to do.

Next came Hugh Hefner, the god of hedonism, who said, "If it feels good, do it." Now we had young adults without discipline, obligations, or responsibilities who found out that what they did was fun.

With all due respect to the women of this country, soon came the women's lib movement. I respect and admire the movement as much as anybody else, but it promoted, initially, a few fallacies as far as I'm concerned. One was that being a good housewife and mother was the lowest form of existence for any female. Those who aspired to that nobel profession were ridiculed in the media. It became important for women to succeed in a career, and latch-key children became a norm. Why did we do it? So we would have more material things that we could give our children in place of love and discipline, which they cried out for.

Thus we have the root cause of our problems today: We adults failed our children because we were not good role models, nor did we take time out to teach them the dangers of alcohol and other drugs. We showered this generation with all the things they wanted. We could afford to do so without allowing them to work for anything and without teaching them to say no or appreciate the value of life and love.

How can we correct our mistakes? By going back to the morality and discipline of our grandparents. The principles they lived by included: love of spouse and family, love of children, discipline of children, high goal-setting, and emphasis on the family unit.

It sounds simple; but I have found in medicine—as a pre-med student, medical student, and practicing physician—that anytime somebody gave me a complicated answer to a problem, it was usually wrong. The best answers are usually very simple—that is the way nature works.

Dr. Greco, a thoracic surgeon in Luzerne County, is the State Society's Twelfth District Trustee.



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Zantac®

ranitidine HCl/Glaxo 150 mg and 300 mg tablets

Zantac® 150 Tablets
(ranitidine hydrochloride)

Zantac® 300 Tablets
(ranitidine hydrochloride)

Zantac® Syrup
(ranitidine hydrochloride)

BRIEF SUMMARY

The following is a brief summary only. Before prescribing, see complete prescribing information in Zantac® product labeling.

INDICATIONS AND USAGE: Zantac® is indicated in:
1. Short-term treatment of **active duodenal ulcer.** Most patients heal within four weeks.
2. **Maintenance therapy** for duodenal ulcer patients at reduced dosage after healing of acute ulcers.
3. The treatment of **pathological hypersecretory conditions** (eg, Zollinger-Ellison syndrome and systemic mastocytosis).
4. Short-term treatment of **active, benign gastric ulcer.** Most patients heal within six weeks and the usefulness of further treatment has not been demonstrated.
5. Treatment of **gastroesophageal reflux disease (GERD).** Symptomatic relief commonly occurs within one or two weeks after starting therapy. Therapy for longer than six weeks has not been studied.

In active duodenal ulcer; active, benign gastric ulcer; hypersecretory states; and GERD, concomitant antacids should be given as needed for relief of pain.

CONTRAINDICATIONS: Zantac® is contraindicated for patients known to have hypersensitivity to the drug.

PRECAUTIONS:

General: 1. Symptomatic response to Zantac® therapy does not preclude the presence of gastric malignancy.
2. Since Zantac is excreted primarily by the kidney, dosage should be adjusted in patients with impaired renal function (see DOSAGE AND ADMINISTRATION). Caution should be observed in patients with hepatic dysfunction since Zantac is metabolized in the liver.

Laboratory Tests: False-positive tests for urine protein with Multistix® may occur during Zantac therapy, and therefore testing with sulfosalicylic acid is recommended.

Drug Interactions: Although Zantac has been reported to bind weakly to cytochrome P-450 *in vitro*, recommended doses of the drug do not inhibit the action of the cytochrome P-450-linked oxygenase enzymes in the liver. However, there have been isolated reports of drug interactions that suggest that Zantac may affect the bioavailability of certain drugs by some mechanism as yet unidentified (eg, a pH-dependent effect on absorption or a change in volume of distribution).

Carcinogenesis, Mutagenesis, Impairment of Fertility: There was no indication of tumorigenic or carcinogenic effects in lifespan studies in mice and rats at doses up to 2,000 mg/kg/d.

Ranitidine was not mutagenic in standard bacterial tests (*Salmonella, Escherichia coli*) for mutagenicity at concentrations up to the maximum recommended for these assays.

In a dominant lethal assay, a single oral dose of 1,000 mg/kg to male rats was without effect on the outcome of two matings per week for the next nine weeks.

Pregnancy: ***Teratogenic Effects: Pregnancy Category B:*** Reproduction studies have been performed in rats and rabbits at doses up to 160 times the human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Zantac. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: Zantac is secreted in human milk. Caution should be exercised when Zantac is administered to a nursing mother.

Pediatric Use: Safety and effectiveness in children have not been established.

Use in Elderly Patients: Ulcer healing rates in elderly patients (65 to 82 years of age) were no different from those in younger age groups. The incidence rates for adverse events and laboratory abnormalities were also not different from those seen in other age groups.

ADVERSE REACTIONS: The following have been reported as events in clinical trials or in the routine management of patients treated with Zantac®. The relationship to Zantac therapy has been unclear in many cases. Headache, sometimes severe, seems to be related to Zantac administration.

Central Nervous System: Rarely, malaise, dizziness, somnolence, insomnia, and vertigo. Rare cases of reversible mental confusion, agitation, depression, and hallucinations have been reported, predominantly in severely ill elderly patients. Rare cases of reversible blurred vision suggestive of a change in accommodation have been reported.

Cardiovascular: As with other H_2-blockers, rare reports of arrhythmias such as tachycardia, bradycardia, atrioventricular block, and premature ventricular beats.

Gastrointestinal: Constipation, diarrhea, nausea/vomiting, abdominal discomfort/pain, and rare reports of pancreatitis.

Hepatic: In normal volunteers, SGPT values were increased to at least twice the pretreatment levels in 6 of 12 subjects receiving 100 mg qid intravenously for seven days, and in 4 of 24 subjects receiving 50 mg qid intravenously for five days. There have been occasional reports of hepatitis, hepatocellular or hepatocanalicular or mixed, with or without jaundice. In such circumstances, ranitidine should be immediately discontinued. These events are usually

Zantac® 150 and 300 (ranitidine hydrochloride) Tablets
Zantac® (ranitidine hydrochloride) Syrup

reversible, but in exceedingly rare circumstances death has occurred.

Musculoskeletal: Rare reports of arthralgias.

Hematologic: Blood count changes (leukopenia, granulocytopenia, thrombocytopenia) have occurred in a few patients. These were usually reversible. Rare cases of agranulocytosis, pancytopenia, sometimes with marrow hypoplasia, and aplastic anemia have been reported.

Endocrine: Controlled studies in animals and man have shown no stimulation of any pituitary hormone by Zantac and no antiandrogenic activity, and cimetidine-induced gynecomastia and impotence in hypersecretory patients have resolved when Zantac has been substituted. However, occasional cases of gynecomastia, impotence, and loss of libido have been reported in male patients receiving Zantac, but the incidence did not differ from that in the general population.

Integumentary: Rash, including rare cases suggestive of mild erythema multiforme, and, rarely, alopecia.

Other: Rare cases of hypersensitivity reactions (eg, bronchospasm, fever, rash, eosinophilia), anaphylaxis, angioneurotic edema, and small increases in serum creatinine.

OVERDOSAGE: Information concerning possible overdosage and its treatment appears in the full prescribing information.

DOSAGE AND ADMINISTRATION: (See complete prescribing information in Zantac® product labeling).

Active Duodenal Ulcer: The current recommended adult oral dosage is 150 mg or 10 ml (2 teaspoonfuls equivalent to 150 mg of ranitidine) twice daily. An alternate dosage of 300 mg or 20 ml (4 teaspoonfuls equivalent to 300 mg of ranitidine) once daily at bedtime can be used for patients in whom dosing convenience is important. The advantages of one treatment regimen compared to the other in a particular patient population have yet to be demonstrated.

Maintenance Therapy: The current recommended adult oral dosage is 150 mg or 10 ml (2 teaspoonfuls equivalent to 150 mg of ranitidine) at bedtime.

Pathological Hypersecretory Conditions (such as Zollinger-Ellison syndrome): The current recommended adult oral dosage is 150 mg or 10 ml (2 teaspoonfuls equivalent to 150 mg of ranitidine) twice a day. In some patients it may be necessary to administer Zantac® 150-mg doses more frequently. Doses should be adjusted to individual patient needs, and should continue as long as clinically indicated. Doses up to 6 g/d have been employed in patients with severe disease.

Benign Gastric Ulcer: The current recommended adult oral dosage is 150 mg or 10 ml (2 teaspoonfuls equivalent to 150 mg of ranitidine) twice a day.

GERD: The current recommended adult oral dosage is 150 mg or 10 ml (2 teaspoonfuls equivalent to 150 mg of ranitidine) twice a day.

Dosage Adjustment for Patients with Impaired Renal Function: On the basis of experience with a group of subjects with severely impaired renal function treated with Zantac, the recommended dosage in patients with a creatinine clearance less than 50 ml/min is 150 mg or 10 ml (2 teaspoonfuls equivalent to 150 mg of ranitidine) every 24 hours. Should the patient's condition require, the frequency of dosing may be increased to every 12 hours or even further with caution. Hemodialysis reduces the level of circulating ranitidine. Ideally, the dosage schedule should be adjusted so that the timing of a scheduled dose coincides with the end of hemodialysis.

HOW SUPPLIED: Zantac® 300 Tablets (ranitidine hydrochloride equivalent to 300 mg of ranitidine) are yellow, capsule-shaped tablets embossed with "ZANTAC 300" on one side and "Glaxo" on the other. They are available in bottles of 30 (NDC 0173-0393-40) tablets and unit dose packs of 100 (NDC 0173-0393-47) tablets.

Zantac® 150 Tablets (ranitidine hydrochloride equivalent to 150 mg of ranitidine) are white tablets embossed with "ZANTAC 150" on one side and "Glaxo" on the other. They are available in bottles of 60 (NDC 0173-0344-42) and 100 (NDC 0173-0344-09) tablets and unit dose packs of 100 (NDC 0173-0344-47) tablets.

Store between 15° and 30° C (59° and 86° F) in a dry place. Protect from light. Replace cap securely after each opening.

Zantac® Syrup, a clear, peppermint-flavored liquid, contains 16.8 mg of ranitidine hydrochloride equivalent to 15 mg of ranitidine per 1 ml in bottles of 16 fluid ounces (one pint) (NDC 0173-0383-54).

Store between 4° and 25° C (39° and 77° F). Dispense in tight, light-resistant containers as defined in the USP/NF.

July 1990

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Please see Brief Summary of Prescribing Information on adjacent page.

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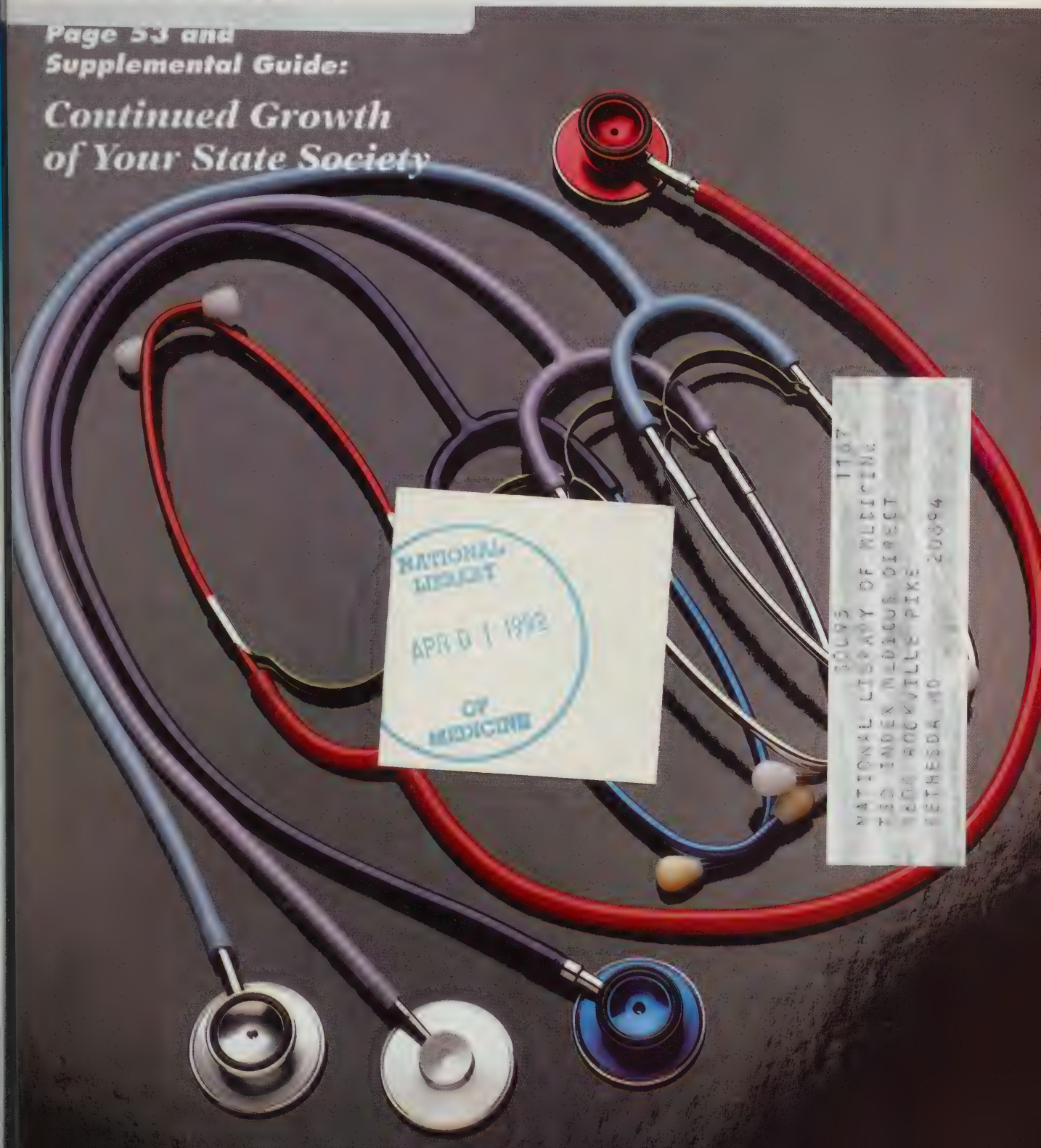
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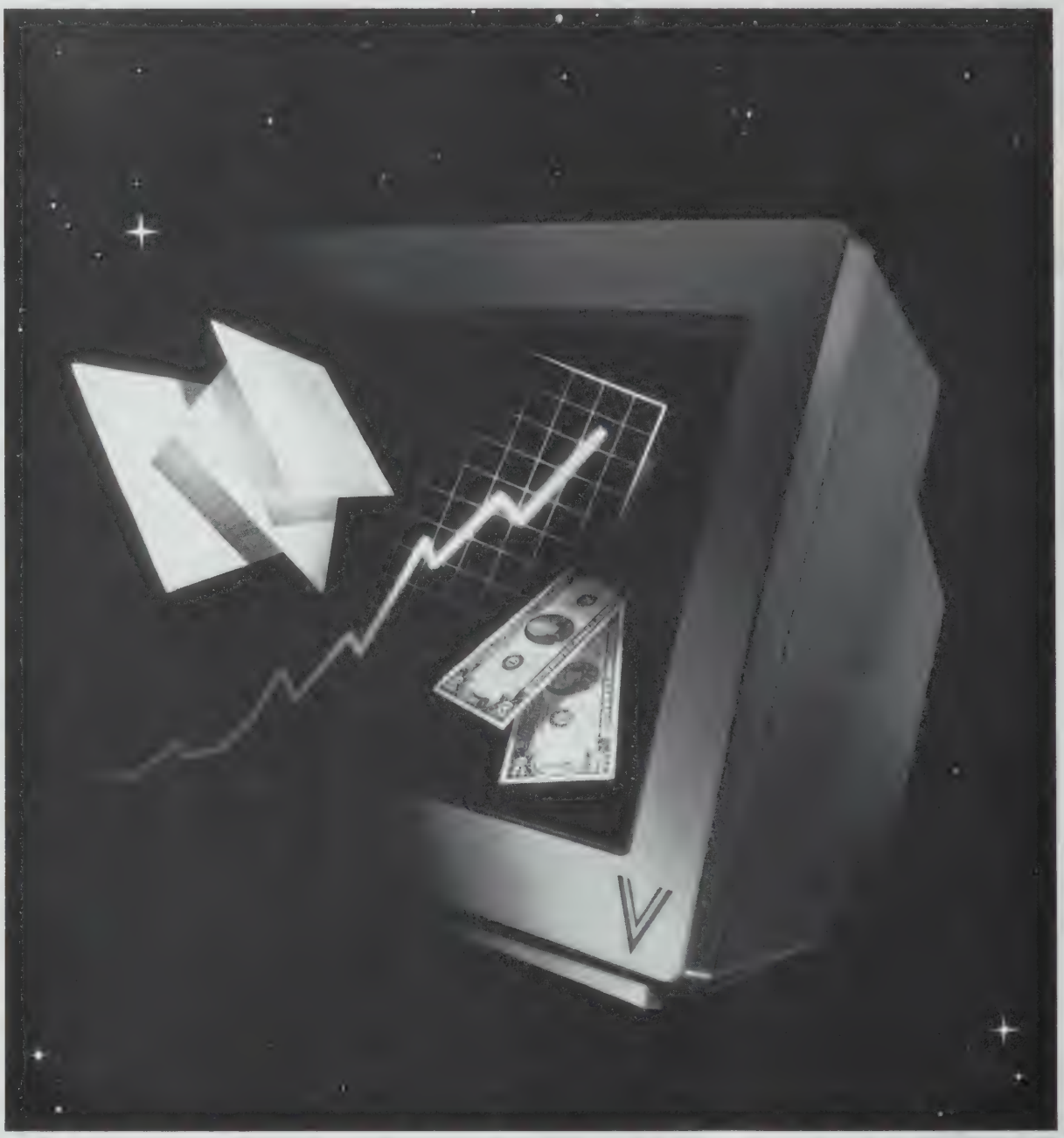
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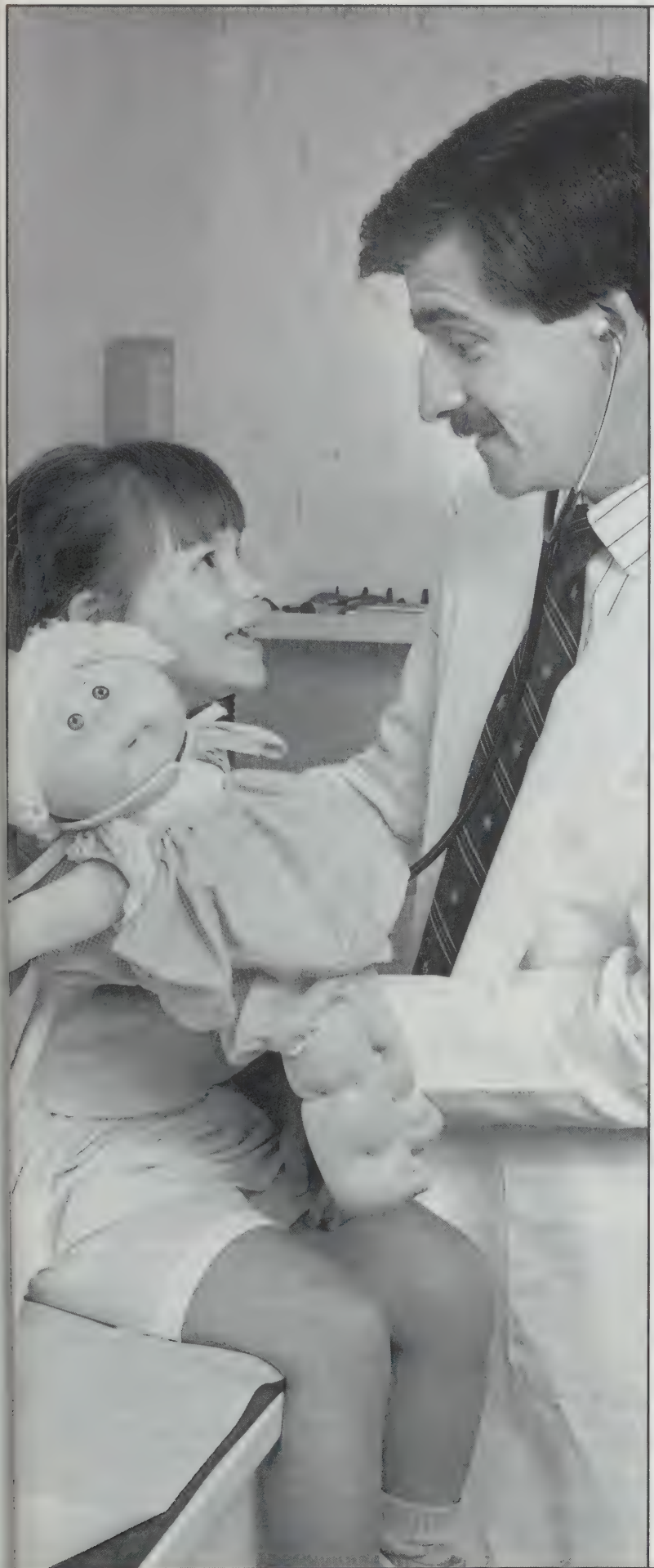
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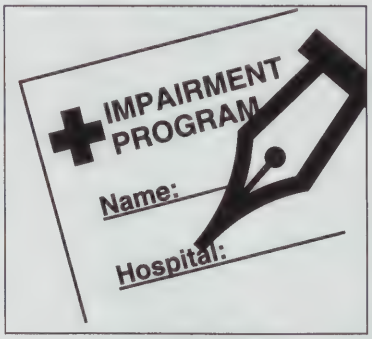
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Wood engraving after Honore` Daumier.
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PENNSYLVANIA MEDICINE (ISSN 0031-4595) is published monthly by the Pennsylvania Medical Society, 777 East Park Drive, Harrisburg, PA 17111.
SUBSCRIPTIONS: $20 per year— United States and Canada; $30—all others. Single issues $3.00 per copy prepaid; special issues cost more.
POSTMASTER: Send address changes to PENNSYLVANIA MEDICINE, 777 East Park Drive, PO Box 8820, Harrisburg, PA 17105–8820. Second class postage paid at Harrisburg, PA 17105.

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OSHA BLOODBORNE PATHOGEN REGS BECOME EFFECTIVE: The final regulations on occupational exposure to bloodborne pathogens, released by the Occupational Safety and Health Administration (OSHA) in December, became effective March 6. The regulations apply to occupational exposure to blood or other potentially infectious materials in all medical settings and are critical for physicians. The State Society is offering programs in April to help physicians meet the OSHA requirements. For additional information, call the Society's Department of Physician Services at 1-800-228-7823. The AMA has also prepared a package of materials to help physicians with implementation. For information, call 1-800-AMA-3211.

HCFA FURTHER EXTENDS E/M CODE GRACE PERIOD: The Health Care Financing Administration (HCFA) has announced a further extension of the grace period for the new Medicare evaluation and management (E/M) codes which went into effect January 1. Physicians may use either the old or the new E/M codes for Medicare services rendered on or before February 29, 1992, providing claims are received by Medicare on or before April 30. The previous grace period required that claims be processed by March 31.

STATE SOCIETY AND HAP SHOW SUPPORT FOR WORKERS' COMPENSATION REFORM: On March 9, a large contingent of representatives from the Pennsylvania Medical Society and the Hospital Association of Pennsylvania (HAP) visited with legislators in Harrisburg in support of reasonable workers' compensation reform. The Society and HAP oppose linking the state workers' compensation system to the confusing new Medicare system and cooperatively developed an alternative based on an established federal workers' compensation schedule. The intent of the visits was to solicit support of that plan. Consideration was expected by the Senate Labor and Industry Committee.

CLIA REGS RELEASED: The Clinical Laboratory Improvement Amendments of 1988 (CLIA-88) were released on February 28 in three parts: the complexity model or laboratory standards, the compliance or sanctions requirements, and the fee schedule or user fees. The regulations are expected to become effective in early fall and be phased in over a period of two to three years.

FDA PANEL RECOMMENDS IMPLANTS REMAIN ON MARKET: After three days of hearings in February, an advisory panel of the Food and Drug Administration (FDA) unanimously recommended that silicone breast implants remain on the market with substantial new restrictions on their use, the AMA reported. Only women enrolled in experimental trials would be eligible for implants. However, the panel stressed that all women needing reconstruction after cancer surgery would be eligible, as would women with serious breast deformities. FDA Commissioner David Kessler, MD, has promised to act on the panel's recommendation before the end of April.

ACTING STATE INSURANCE COMMISSIONER NAMED: On February 28, the state Insurance Department named Ronald Chronister acting commissioner to replace Constance Foster, who left her position to enter private law practice. Mr. Chronister has been with the department for 22 years, most recently as deputy commissioner for regulation.

AMA TO HOST RBRVS TELECONFERENCE: On March 27, the AMA will host a nationwide teleconference, "Medicare Physician Payment Reform: A New System of Rules and Codes." The program, airing from 2:30-4:00 p.m., will address issues and questions on the new payment system and the new CPT codes. For additional information on telecast sites, call 1-800-228-7823.

WILENSKY APPOINTED TO WHITE HOUSE: Gail Wilensky, PhD, has been appointed to the White House as deputy assistant to the president for policy development. No word is yet available about who will replace her as HCFA administrator, but Lou Hayes will serve as acting administrator.

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Law and Medicine: Where the Similarity Ends

John W. Mills, MD
Medical Editor

A recent lead article in my local newspaper highlighted a law firm which is experiencing solid growth by focusing on the expanding market in personal injury litigation. The article noted that this firm refers all other legal matters to consulting colleagues and concentrates exclusively on "slip and fall" accidents, product liability, and auto accident injuries. They liken themselves to medical professionals who concentrate their practice in a certain area of medicine to attain a greater degree of proficiency in that area. The attorneys say they have "successfully combined modern marketing techniques with traditional legal professionalism to create a law firm of significant status and integrity."

There is little doubt that limiting practice to a specific area will allow greater proficiency in that area, but that's about where the similarity between medicine and law ends. Both *are* considered professions, but I take issue with what was once called "ambulance chasing," i.e; modern market techniques. The Supreme Court's assertion that it is ethical and legal for professions to advertise does not make it "right" or a standard to be followed.

My other concerns relative to this article are two-fold: the ever-increasing liability issues coupled with ever-increasing restraints when treating the elderly.

Briefly, the liability issue continues unabated in the U.S. With better than 30 percent of the judgment going to attorneys, it is easy to see how one can build a lucrative law practice. Another 20-30 percent goes for "costs," so the plaintiff frequently realizes 25 percent or less of the settlement. Because the settlement is usually tax free, this encourages people to sue, as do attorneys' advertisements, television spots, letters, and phone calls to auto accident unfortunates. We are suit-happy and have promulgated a "someone has to pay" mentality. We have five percent of the world's population in this country and 90 percent of the world's lawyers—that should speak for itself.

Secondly, while our legal brethren continue to proliferate their practices at everyone's expense, we in the health care professions have just been saddled with the RBRVS payment system for Medicare. RBRVS further restricts the way we treat patients and ratchets down the money available to health care professionals. Yes, the system is better than expenditure targets, and it may level off the "paying field" between medical and surgical types. But the net result is more restrictive medical practice to an ever-growing Medicare age group with less money to cover this practice.

Finally, the specter of dissatisfied patients looms as a result of our practice restrictions and cutbacks. Who gets blamed and ultimately sued? Not HCFA, not Congress, not Blue Cross/Blue Shield—but health care providers.

Follow this line of thought: preventative medicine is not paid for by Medicare, thus illness in elderly patients frequently costs more because it wasn't diagnosed early. Medicare recipients are increasing in number, and with a fixed allotment of funds by Congress or HCFA, there will be less for each patient. Elderly patients generally consume more time per office visit because of special problems in communicating with them. Yet Medicare specifically doesn't cover this unless it is more than 50 percent of the visit.

We are urged to be more efficient, yet we hear the complaints: "He's/she's too busy to talk to me," or "He/she rushes me in and out like an assembly line." Thus risk management takes a backseat when we don't have the time to talk with patients, and the unhappy patient is more prone to consider litigation.

So we've come full circle. The legal profession grows at our expense; Medicare restricts our practice via mandated rules and monetary restraints; we are urged to be more efficient at the expense of good communication and risk management; and the legal profession again grows at our expense. This *must* end, or this county will ultimately have a *real* health care crisis.

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— Daniel Goldberg
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Working Together To Build Our Ranks

Robert N. Moyers, MD



The Pennsylvania Medical Society was founded in 1848 to serve its members' interests. I'm sure our colleagues who have gone before us understood very well the political realities of their day. They knew how and where to apply their efforts to clean up public water systems, to vaccinate children, and to establish standards for the medical profession.

They serve as an example to us of what physicians, working together, can accomplish. Strength doesn't lie only in numbers, but strength *begins* in numbers.

Since I assumed the role of president, my energies have been spread over a wide range of issues—from RBRVS to workers' comp to auto insurance. And no matter how busy I have been, how many legislators I have spoken to, or how many phone conferences I attended, I have never lost sight of the importance of membership recruitment.

In fact, as I become deeply involved in all of these issues, I'm even more aware of how important it is for those of us within organized medicine to reach out to our colleagues within the profession.

The time has passed when each physician could go his or her own way and still be able to practice medicine the way we think it should be practiced. That is why one of my primary goals this year is membership retention and growth.

There are two sides to this issue of recruitment.

The first side—and this is the one we tend to emphasize most—is that physicians need a strong organization to function effectively in the public arena. Sometimes, our colleagues interpret this to mean that we want their money to strengthen our organization for its own sake, or for our own sake.

This is where we perhaps have not been as effective as we should be. Because the second side, the flip side of recruitment, is the more important one.

The fact is, we know something that our non-member colleagues do not know. We in organized medicine are the ones who testify at hearings. We are the ones who get inside the legislative process and see how it is or is not working.

Our colleagues do not see what we see. And so they can continue to believe that they can do nothing and that nothing bad will happen. We know better. And we've learned it the hard way.

I think we actually have an obligation to our colleagues, not to allow them to sit back and become the victims of systems and procedures they know little about. We must put our experience—our successes and our failures—at the service of our fellow physicians.

I am convinced that if we tell them forthrightly what we have learned and what we need to accomplish on their behalf, they will join us.

I am asking you personally to reach out to your colleagues. The simplest way to do this is to invite them to your meetings, so they can learn first-hand about the efforts of physicians working on their behalf.

I have also asked each county medical society to make a commitment to the following activities: a phone-a-thon in connection with our annual spring member retention activities, and a peer-to-peer recruitment effort with non-members before the end of the year.

To be effective in peer-to-peer contact, a physician must be convinced of the value of organized medicine. I'd like you to think about the information you have received through your Society that you would not have received otherwise. I'd like you to recall the times you called the Society to ask a question, to order a special publication, or to sign up for a seminar or workshop. I'd like you to place a value on the comradeship you enjoy at the local, state, and national levels.

Then I'd ask that you spread the word. The stronger we are, the more effective we can be in protecting the practice of medicine.

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Wednesday, April 1, 1992

Thrombolytic Therapy in Myocardial Infarction—1992

Moderator: Ami E. Iskandrain, MD

3:00-3:30	Streptokinase, t-PA, anistreplase: Drug selection and changing criteria for patient selection	*Bernard L. Segal, MD*
3:30-4:00	Management of patients with acute myocardial infarction after thrombolytic therapy: Infarct sizing, assessment of results, detection of ischemia	*Mario Verani, MD* *Director of Nuclear Cardiology;* *Professor of Medicine, Baylor College of Medicine*
4:00-5:00	Case Presentations	*Joseph Lemlek, DO*
	Panel Discussion	*Jaekyeong Heo, MD* *J. David Ogilby, MD* *Ancil A. Jones, MD*

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ALTERNATIVE OFFERED TO RECORDS MANDATES

Through the pages of your widely read journal, I would like to bring before your readers an important subject pertaining to doctors who relocate or retire from practice in Pennsylvania.

As we all know, it is expected that doctors terminating their practices will retain all original records of their patients for a period of 7-12 years. Copies of these records are expected to be made by the relocating doctor to be given to patients seeking other doctors.

This rule is more easily made and written than carried out for all doctors, but especially for solo practitioners leaving Pennsylvania for a distant state to take up a salaried or other position. This law could be most inconvenient and well-nigh impossible to follow. How is the doctor expected to keep in his or her guarded security thousands of pages of patient records, let alone carry them wherever he or she goes or pay for their storage?

I strongly urge liability attorneys, insurance companies, and the Pennsylvania Medical Society to reconsider this quixotic law and change it.

My proposal is for doctors to leave the responsibility of secure keeping of the records to individual patients who can take them anywhere, keep them in their homes, or destroy them.

In case of litigation, it would be the responsibility of the individual patient to make his or her records available to the attorney, and the right of the defending attorney also to obtain this record in preparing the case.

I would be most interested in knowing the opinions and reactions to my proposal from all parties, including patients, if they would read this letter. Thank you.

B. Viswanathan, MD, FACP
Gettysburg

Medical Editor's Note: Our legal council is attempting to get some factual evidence on this, and at the same time, the State Society has considered and is still considering the possibility of providing some type of a service for physicians who have retired and wish to have their medical records microfilmed or kept on file.

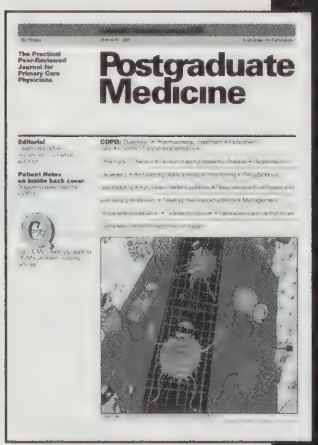
Letting patients keep their records is not a good idea, since the records are legal documents and are your property. Copies may be given to patients if a physician wishes to do so or if the patient requests them, but the originals are your only defense in a suit.

The editors of PENNSYLVANIA MEDICINE encourage comments about the magazine and its contents, as well as viewpoints on current medical issues. Please send letters to: Editor, PENNSYLVANIA MEDICINE, 777 East Park Drive, P.O. Box 8820, Harrisburg, PA 17105-8820. Letters are published at the discretion of the managing editor and are subject to editing.

US THEM



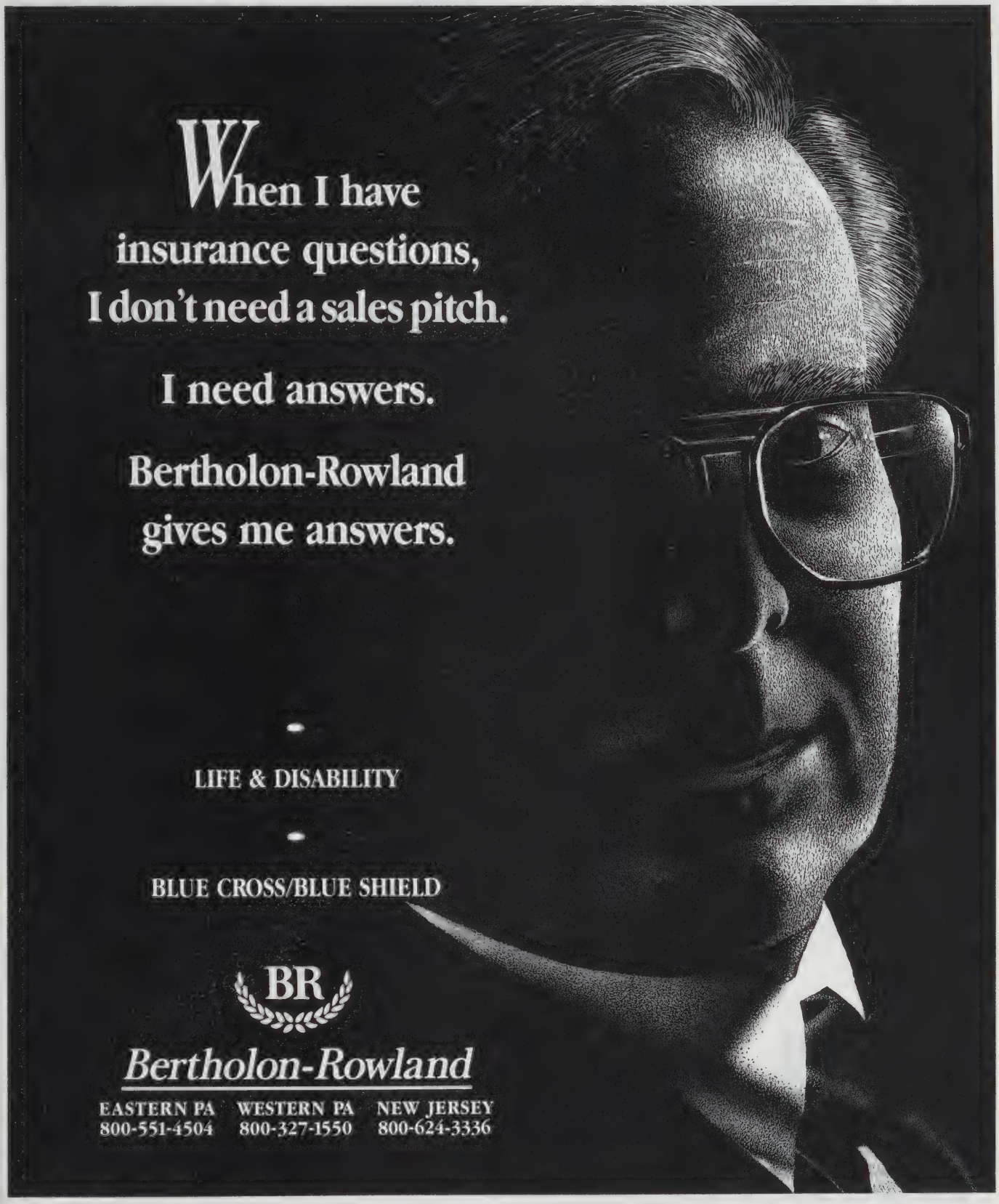




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REGIONAL RBRVS MEETINGS WELL-ATTENDED

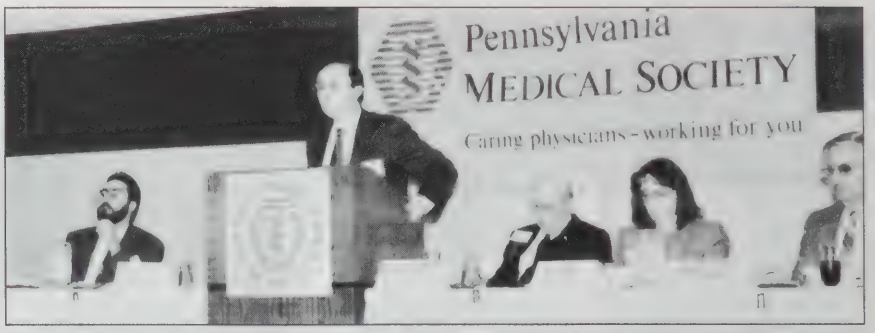
More than 2,560 physicians attended eight regional State Society meetings held in January which alerted them to changes in the Medicare program as a result of Medicare Physician Payment Reform. Initial evaluations from attendees indicate that the presentations were well-received.

The meetings were held in Pittsburgh, Harrisburg, Allentown, Philadelphia, Erie, and State College. State Society leaders and staff members, and Pennsylvania Blue Shield representatives, addressed the rationale and mechanics of the new reimbursement process implemented on January 1, as well as the new visit codes and payment policy changes. An update on the status of the Commonwealth's attempts to reform workers' compensation was also presented. Following formal presentations, the speakers joined together as a panel to answer attendees' questions.

Comments from physicians attending the meetings around the state are favorable, saying they believe the information was understandable, the dialog between speakers worked well, and the Blue Shield information was useful. Seventy-six percent of attendees who completed initial evaluations rated the meetings as "excellent" or "good."

The American Medical Association (AMA) also held a series of seminars across the country to promote understanding of the new RBRVS payment mechanism. On February 11, a number of physicians gathered at the AMA meeting in Pittsburgh. The program featured an overview of the payment system, a discussion of the new CPT visit codes, a presentation by Health Care Financing Administration officials of major Medicare program directives, and a look ahead to expected regulatory and legislative changes. The AMA also scheduled an extensive question-and-answer panel to conclude the program.

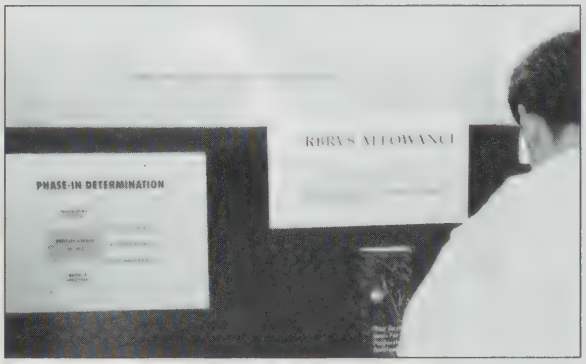
Follow-up meetings sponsored by the State Society were scheduled in late January and early February for physicians' office staffs to learn how to use the new CPT codes.



Thomas H. Malin, MD (at podium), spoke on the State Society's behalf at the Harrisburg meeting, attended by 248 physicians.



Meeting attendees asked specific questions of State Society and Pennsylvania Blue Shield panelists during an extensive question and answer session in Philadelphia.



The Society's RBRVS display was set up throughout the state to show attendees how the new system works and provide them with additional materials about the system and the Society.

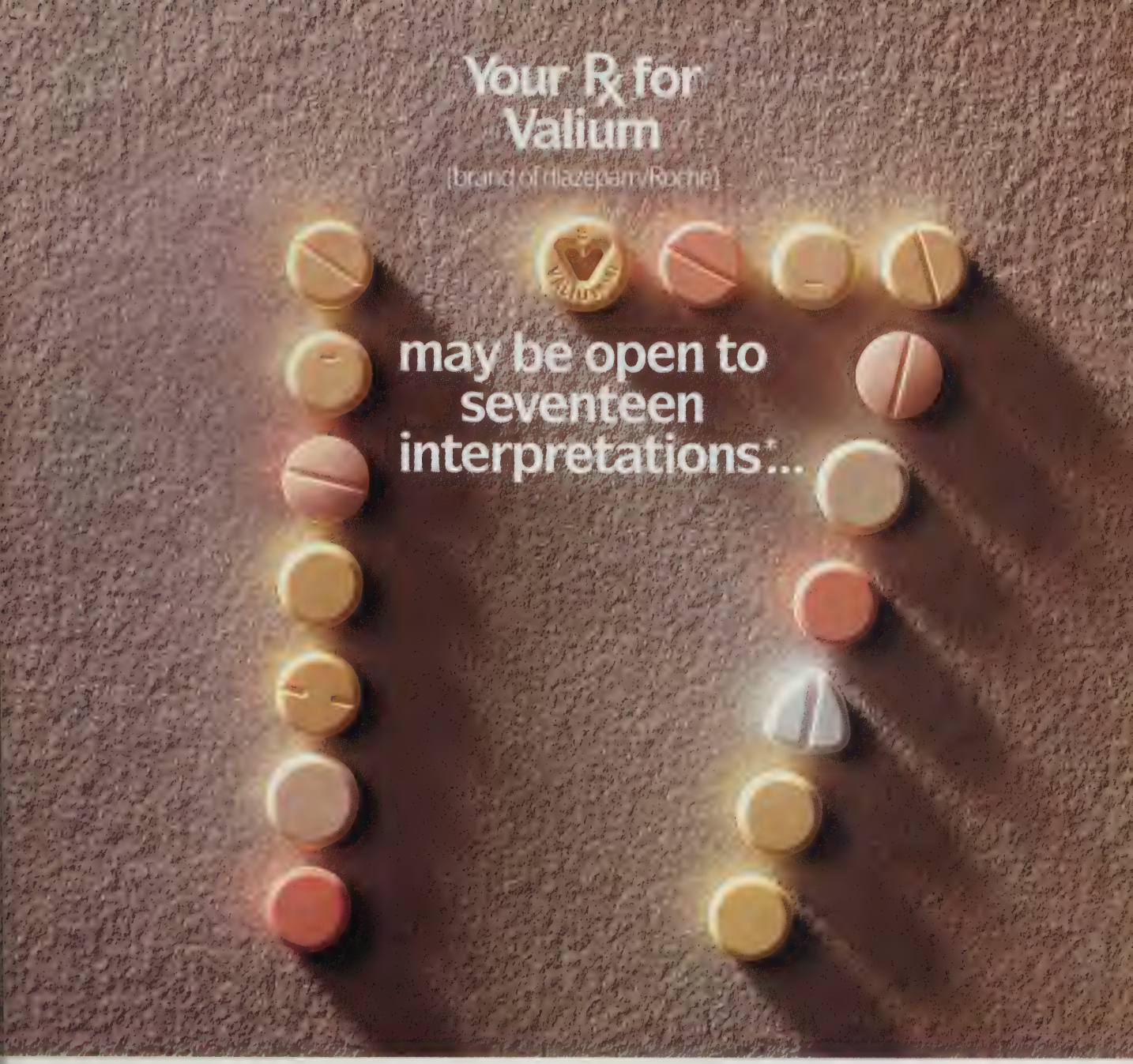
PUBLICATIONS AVAILABLE

The State Society has developed several publications to assist physicians in converting to the new RBRVS method of Medicare payment. For additional information or to order the following materials, send name, address, phone number, and check to Department of Physician Services, State Society headquarters, Harrisburg (Pennsylvania residents: please add 6 percent sales tax to your order); or call 1-800-228-7823.

- *Visit Code Information Kit* (includes analysis of E/M coding system)—complimentary to members, not available to non-members.
- *Medicare Evaluation and Management Codes: A Pocket Reference for Physicians*—first copy complimentary to members/ additional copies $2.00 each, $5.00 per copy for non-members.
- *Medicare Physician Payment: Before and After RBRVS*—first copy complimentary to members/ additional copies $2.00 each, $5.00 per copy for non-members.
- *Practice Management Consulting Network*—first copy complimentary to members/additional copies $2.00 each, $5.00 per copy for non-members.

AMA OFFERING *CPT 1992*

CPT 1992, the annual publication listing AMA 1992 Current Procedural Terminology (CPT) codes, is now available from the national association. Prices are: $27 for AMA members and $34 for non-members. To order, call 1-800-621-8335.



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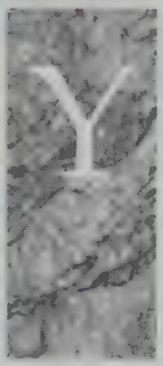
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Medicare Monitoring of Payment Reform

Dennis L. Olmstead

Medicare payment reform became effective January 1, 1992. One aspect is monitoring by Medicare carriers of payment reform initiatives and physician compliance with these initiatives.

Carrier monitoring of payment reform will assist Medicare in identifying changes in coding practices and utilization patterns on a national and regional basis. It will also provide educational feedback to physicians about their utilization and coding of services.

Extensive monitoring will initially focus on use of the new evaluation and management (E/M) services by physicians. Pennsylvania Blue Shield, as the Medicare carrier, will conduct that monitoring through an Early Claims Review Program and Visit Code Comparative Performance Reports. Other payment initiatives being implemented include Global Surgical Modifier Monitoring, Average Anesthesia Time Monitoring, and the Medicare Current Beneficiary Survey.

Early Claims Review Program

The Early Claims Review Program is intended to provide the Health Care Financing Administration (HCFA) and the physician community with information about the appropriate use of the new codes. Carriers will review medical records to assess code usage. Beginning in February 1992, and continuing through June 1992, the program will operate as follows:

1) Blue Shield will select a random sample of up to 25 claims per week containing the new E/M codes and consultations.

2) Blue Shield staff will telephone each physician whose claim was selected, and, after explaining the program, request medical records to support the level of service billed on the claim. The telephone contact will be followed by a letter identifying the claim selected for review. Note: no physician will be contacted to provide documentation on more than one claim.

3) Blue Shield staff will review the documentation to determine if the claim code submitted accurately describes the service provided.

4) If the documentation supports the level of E/M service billed, Blue Shield will send a letter to the physician confirming that the correct codes were used.

5) If the documentation fails to support the level of E/M service billed, Blue Shield will inform the physician which code should have been used.

This process is intended to be educational, with no use of punitive measures such as overpayments or sanctions. The program's results will be shared with the State Society on an ongoing basis. This information will be used to further educate members about code usage. E/M codes to be reviewed under the Early Claims Review process are: office visits—99213, 99214, 99215, 99204, 99205; hospital visits—99222, 99223, 99232, 99233; consultations—99244, 99245, 99263, 99255; emergency room visits—99283, 99284, 99285.

Comparative Performance Reports

The second monitoring activity involves Comparative Performance Reports (CPRs). In the past CPRs were used to inform physicians about their individual Medicare practice patterns, compared to those of their specialty and locality peers when their utilization was significantly higher than the norm. The same methodology will be used this year, but only E/M and consultation services will be reviewed. Like Early Claims Review, this program is informational for physicians; however, it does not prohibit Blue Shield from placing a physician on a Provider Audit List. Physicians are encouraged to respond to audits to discuss findings with Blue Shield (see "Monitoring audit tips" on page 17).

Twice in 1992, Blue Shield will profile physicians and send CPRs to those who bill in the top five percent for E/M codes reviewed under the Early Claims Review process. CPRs will contain information about the number of Medicare beneficiaries that the physician treated during the period analyzed, the number of E/M services billed per beneficiary who received an E/M service, and the average number of E/M services provided for all beneficiaries that the physician treated. Similar information will also be provided for the physician's peer group. The information obtained from the CPR program will be

Dennis L. Olmstead is the State Society's director of medical economics.

shared with the Society, the CPT Editorial Panel, and HCFA regarding coding policies that may require clarification.

Global Surgical Modifier Monitoring

In addition to the Resource Based Relative Value System (RBRVS), Medicare has developed new policies regarding global surgical packages, which include payment for pre-operative and post-operative care. Services rendered during periods unrelated to the surgical diagnosis can be reimbursed separately from the global surgical payment.

Physicians have been instructed to use modifiers 24, 25, and 79 to denote that the service rendered should *not* be considered part of global surgical package. Blue Shield will conduct pre-payment medical reviews on claims using modifier 24, which denotes that an unrelated E/M service was rendered by the same physician who performed the procedure during the post-operative period. Blue Shield will be reviewing the required medical record documentation that must be submitted with Modifier 24.

Post-payment review will be conducted on the utilization of modifiers 25 and 79 to identify physicians who use them more frequently then their peers. Modifier 25 denotes that a significant, separately identifiable E/M service was rendered by the same physician on the day he/she performed a procedure. Modifier 79 denotes that an unrelated procedure or service was rendered by the same physician who performed the original procedure during the post-operative period.

Average Anesthesia Time Monitoring

Average Anesthesia Time Monitoring will be conducted by Blue Shield to determine the average amount of time units billed per anesthesia procedure by anesthesiologists under their jurisdiction. Results will be compared to a national average provided by HCFA. Blue Shield will inform anesthesiologists if they bill at a significantly greater level than the national average.

Medicare Current Beneficiary Survey

HCFA has developed an on-going, multipurpose survey to be used by all its components concerned with Medicare policy. The survey is conducted to compile information on Medicare use, costs, and beneficiary characteristics. It will also be used to monitor and evaluate the impact of legislation, such as Physician Payment Reform, on beneficiaries—both financially and in terms of access to physician care. The survey is not intended to monitor physician behavior.

At the core of the survey concept is a series of interviews of a representative sample of the Medicare population. Questions will seek to identify patterns of use and cost over time, sources of coverage and payment, assets and income, demographic characteristics, health and functional status, health and work history, and family supports. The first round of the survey occurred between September and December 1991 from a sample of 12,700 beneficiaries nationwide. Pennsylvania's sample totaled 907 beneficiaries in 15 counties. The Society will continue to monitor the survey and HCFA's conclusions.

Monitoring audit tips

The following are tips for physicians' offices in reducing the chances of being audited and in handling audits from third-party payors:

- Respond to Comparative Performance Reports by explaining why your practice utilization patterns may be higher than the norm.
- Make sure the physician specialty you are enrolled under is correct. Also inform the carrier of any subspecialty under which you practice.
- Do not discuss anything with the auditor during the visit to review medical records. The physician/patient privilege does not apply to services paid by the third-party payor. Have the auditor put any questions in writing, and consult an attorney.
- Require the auditor's identification and a business card. Determine the type of audit to be conducted (e.g., licensing department, fraud unit, routine, etc.).
- If the third-party payor wishes to "offset" future payments based on the amount supposedly overpaid during an appeal, negotiate with the payor to "offset" as little as possible until the appeal is finalized. Ideally, "offsets" are not recommended since they can create an accounting nightmare. While the appeal is pending, attempt to pay back a portion of what is due to avoid offsets.
- Do not use the words "routine" and "screening" in medical record documentation since many insurance carriers do not pay for such services.
- Challenge third-party payors' statistical methodology used to make projections for overpayments from their audit sample. Underpayments should also be projected, as well as the overpayments.
- Obtain relevant manual provisions or other communications from insurance carriers to keep track of the dates policies became applicable. This is important in requests for retroactive payments.
- Document medical records thoroughly. Follow up phone conversations with carrier representatives in writing, requesting written confirmation of the phone call. Maintain all carrier communications.
- Become familiar with all of your rights to appeal audit findings.

RESOLVING UMWA FUNDING PROBLEMS

The United Mine Workers of America (UMWA) Health and Benefit Fund has experienced funding problems, which has resulted in reduced payments to physicians for services rendered to UMWA beneficiaries. Since July 1990, UMWA has only paid the Medicare Part B portion of physicians' bills and not the Fund's portion (e.g., coinsurance and deductibles).

As a result of the Fund's financial problems, UMWA solicited physicians to sign an agreement accepting a discount on the Fund's payment obligation. Physicians who signed the agreement were paid at the discounted rate, but those who did not received only the Medicare portion and were left with balances owed by UMWA.

A February 10, 1992, decision by representatives of the UMWA Fund will temporarily ameliorate the problem of reimbursing physicians for the Fund's share prospectively and retroactively for unpaid services. Nationally, payments are expected to total tens of millions of dollars.

The money to repay the outstanding balances did not come as a result of any resolution between mine owners and the UMWA Fund regarding contributions, but rather it was an internal decision by the Fund to slow down payments for other medical care benefits that are not covered under the Medicare program (e.g., prescription drugs and vision care). Pressure exerted by physicians and organized medicine influenced to a degree the Fund's decision.

As a result of the February 10 decision, the Fund's share will begin to be paid on claims processed after February 17, 1992. Retroactive payments will also begin on or around that time. Physicians are not required to resubmit previously submitted claims, but rather automatic adjustments will be made on balances due. Payments will be made on the basis of the oldest claims first, and UMWA expects the process to take several months.

Physicians who agreed to the original discount will not receive retroactive payments on claims processed before the agreement was signed, but will receive additional reimbursement from the agreement date forward. Physicians who did *not* sign a discount agreement will receive the Fund's share for claims processed from July 1990 forward.

The State Society and the American Medical Association will continue to monitor the issue and seek a permanent solution to the UMWA Fund problem.

UPDATE: NEW PHYSICIAN REDUCTIONS UNDER MEDICARE

As reported in the February 1992 issue of PENNSYLVANIA MEDICINE, physicians rendering services to Medicare Part B beneficiaries during their first through fourth years of practice will have their payment rates reduced, with limited exceptions. The following updated information supplements that article.

Medicare Part B services

Under Medicare payment reform, Part B services must be rendered to beneficiaries during a certain time frame for physicians to qualify their years of practice. The Health Care Financing Administration (HCFA) has clarified that not only do the services have to be rendered, but *they must also be billed to Medicare Part B.*

Billings for such services do not necessarily have to be submitted by the rendering physician, but instead can be billed by the entity employing the physician. For example, a physician compensated by a salary from a hospital where services are rendered would not bill directly for the services; the hospital would bill Medicare Part B using its own provider number. Also, billing is not required during the month in which services were rendered, but rather within the required time frame established by regulation.

Moonlighting

The State Society recommends that residents moonlight so their resident years count toward their new physician years. Under the Commonwealth's Medical Practices Act, guidelines are established for resident moonlighting:

- If the resident graduated from a medical school accredited by the Liaison Committee for Medical Education (LCME), a second-year resident is permitted to moonlight if the residency director approves; the resident would be issued an interim limited license number.
- If the resident did not graduate from an LCME-accredited medical school, moonlighting is only possible during the third year of residency.
- An unlimited license is issued to a resident after completion of the second year for residents who graduated from an LCME-accredited medical school. Although residency director approval is not required by law to moonlight with an unlimited license, some residency programs do prohibit moonlighting even if the resident has an unlimited license. An unlimited license would be issued to a resident after completion of the third year for those who did not graduate from an LCME-accredited medical school.
- A resident participating in a moonlighting program under an interim limited license is permitted to obtain a provider number from Medicare. The provider number is only valid for the period of time for which the license has been issued. Once the license expires and an unlimited license is obtained, the resident must then reapply for a provider number from Medicare.

Challenging Medicare's determination

Physicians who believe the Medicare carrier has incorrectly determined their year of medical practice can request correction by writing to: Pennsylvania Blue Shield, Medicare Provider Reimbursement Inquiry and Monitoring, P.O. Box 890316, Camp Hill, PA 17089-0316, ATTN: Connie Sweigart, Manager.

The letter should include all of the applicable information, including where and when the delivery of services occurred, a provider number, the employer's name and address if applicable, records of Medicare Part B payments (Form 1099) if available, and any other information to substantiate the claim. Note: moonlighting and other Medicare Part B services billed under another physician's provider number do not qualify as part of the new physician reduction criteria.

Dennis L. Olmstead, the State Society's director of medical economics, contributed to this page.

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Helping Hospitals Cope with the Impaired Physician

Maria T. Montesano
Assistant Managing Editor

With the addition of the new hospital physician health committees program and the expansion of already existing programs, the Physicians' Health Programs (PHP) of the Society's Educational and Scientific Trust continues to promote the professional and personal well-being of Pennsylvania's physicians.

Hospitals are a major source of support for the Physicians' Health Programs (PHP), a service of the Pennsylvania Medical Society's Educational and Scientific Trust. In return for financial support, PHP is developing a new program to help hospitals identify, credential, and monitor the alcohol- and drug-impaired, or neuropsychiatrically impaired physician.

For years, many of Pennsylvania's hospitals have offered employee-assistance programs for staff members. However, since physicians are not usually paid directly by hospitals, such programs may not be available to them; and if available, they are often not utilized by physicians. The development of the hospital physician health committees program is an effort to address the need for assistance programs for physicians in the Commonwealth.

"What we want to do is help hospitals revise their organizational culture and formal policies about impairment and physician health issues so they can develop an effective impairment program for the medical staff," says Penelope Ziegler, MD, PHP medical director. Currently, PHP is developing a pilot program to be tested at several Pennsylvania hospitals. PHP also intends to solicit input from the Joint Commission on Accreditation of Health Care Organizations (JCAHCO) and other state agencies which are interested in hospitals developing effective impairment programs.

The long-term goal of the program is to provide a package of suggested guidelines, policies, and procedures for hospitals to use in developing such policies. The program is in its earliest stages: "The policy for identifying the impaired physician is still in draft form," according to Dr. Ziegler. However, PHP does have a flow chart of the guidelines it is using for internal development, and it will begin to meet with medical staff and hospital representatives during 1992.

The program also strives to teach hospitals how to respond to a recovering physician applying for privileges. The availability of the National Practitioner Data Bank (NPDB) in the past two years has led to confusion among employer hospitals. NPDB makes information about physicians available to hospitals, including information about any impairment problems physicians may have had and any recovery programs in which they participate. But Dr. Ziegler says, "Now that the hospitals are getting that information before they hire physicians, they aren't quite sure what to do with it."

Not hiring a physician because such information is known is increasingly hard to defend. She adds, "One major ethical and moral question immediately arises in such situations: is it fair to a practicing physician who is rehabilitated to be denied privileges because the hospital does not know how to monitor the physician? Also, the new Americans with Disabilities Act offers protection to people in recovery, so such actions by hospitals could be construed as discrimination."

Identifying and dealing with impaired physicians will remain a concern for Pennsylvania's 300-plus hospitals. While PHP will continue to work with impaired

physicians on an individual basis, hospitals need to establish a program that encourages early identification and referral, and recognizes and supports the recovering physician. Through the hospital physician health committees program, PHP will offer help in that endeavor.

Expansion of current programs

Apart from impairment programs, PHP offers a variety of programs to help physicians cope with professional and personal stress. In 1992 PHP hopes to expand its services to reach even more physicians in need of support.

The Litigation Stress Program was originally developed to provide emotional support to physicians involved in lawsuits. The program primarily encourages the development of local support networks, the linkage of defendant physicians with supportive colleagues, and the education needed to cope with stress. This year PHP will expand the program to address stress-related problems "as a whole," including stress caused by working with new regulations or within a managed care setting, as well as that caused by medical "hassle factors."

PHP has also taken an active role in helping physicians retire gracefully. Dr. Ziegler says being a physician is "part of your identity" and explains that it is often difficult for physicians to retire. But when aging or medical problems exist which detract a physician's effectiveness, retirement may be necessary. In the past, the State Board of Medicine has had to take legal action against such physicians to revoke their licenses, often leading to local scandal, according to Dr. Ziegler. Now, however, a cooperative effort between PHP and the Board of Medicine has led to a retirement affidavit which allows physicians to retire their licenses without public prosecution.

Finally, PHP provides specific groups, such as medical students and disabled/handicapped physicians, with educational and referral information. According to Dr. Ziegler, "Physicians can contact us for support or information related to *any* area of their personal and professional well-being, and we will do our best to help."

For the future, PHP recognizes that there will be a need to provide support and assistance to physicians who become infected with HIV. Dr. Ziegler says, "PHP is currently exploring what type of program we might be able to develop." For 1992, though, she and her staff will continue to expand existing programs as well as the physician support network, and to develop the hospital physician health committees program.

A

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DIAGNOSING VIRAL HEPATITIS

For persons with viral hepatitis, it is very important to identify the specific type of hepatitis since recommendations for control measures depend on it. Despite the bewildering array of laboratory tests available today, specific diagnosis is actually much simpler than it might seem.

The first step in diagnosing a patient with hepatitis is to rule out by history: 1) chemical or drug-induced (particularly alcohol) hepatitis, or 2) systemic infections, such as Epstein-Barr virus or cytomegelovirus, which secondarily affect the liver. Since the various types of viral hepatitis are virtually identical with regard to acute symptoms, laboratory tests are required to make a specific diagnosis.

The most important types of hepatitis to consider are hepatitis A and hepatitis B. Hepatitis A is easily diagnosed by the detection of antibody against hepatitis A (anti-HAV) of the IgM class, which denotes acute infection and is present at symptom onset. Anti-HAV of the IgG class may represent past-resolved infection and have no bearing on the current illness. Hepatitis A is an acute and generally self-limited illness which tends to persist for a few weeks. There is no chronic carrier state associated with it.

Hepatitis B is diagnosed by the presence of the hepatitis B surface antigen (HBsAg), which represents either acute illness or the chronic carrier state. In the presence of symptoms of acute viral hepatitis and in the absence of anti-HAV IgM, the presence of HBsAg suffices for a diagnosis of acute hepatitis B. Approximately 10 percent of these cases will become chronic carriers of hepatitis B and remain so for the rest of their lives. This is an ominous situation. Persistence of the virus often results in persistent and progressive liver damage over several years' time, possibly leading to progressive cirrhosis and less frequently to liver cancer. Also of importance is that infected individuals can transmit the virus to sexual contacts, those with whom they share parenteral exposures, and other close contacts.

Another hepatitis virus was recently discovered called hepatitis C. In the United States, hepatitis C has been found to cause approximately 80 percent of non-A, non-B hepatitis (the five percent of reported viral hepatitis in Pennsylvania that cannot be diagnosed as hepatitis A or hepatitis B). The epidemiology and clinical course of hepatitis C is similar to hepatitis B, and the chronic carrier state is even more ominous than that of hepatitis B. Currently antibody tests are available for hepatitis C, but they are not very sensitive or specific. Also, they do not differentiate between acute infection, the chronic carrier state, and past-resolved infection.

Because control measures against hepatitis C have not been worked out and problems exist in diagnosis, the Department of Health does not have any protocols for the control of hepatitis C and does not take any action against it. This may change as better diagnostic methods and preventative measures become available—at that time, hepatitis C is likely to become a reportable disease.

Dale Tavris, MD, MPH
Pennsylvania Department of Health

TASK FORCE PLANNING CONCENSUS CONFERENCE

The Child Abuse Task Force of the State Society and the Pennsylvania Bar Association is planning a concensus conference on April 27 in Harrisburg. A series of experts will be invited to relay their experiences with the child abuse reporting process and exchange ideas about systematic problems.

For example, physicians are required by law to report any possible cases of child abuse, and follow-up is completed by the Child and Youth Services Agency. However, after filing an initial report, physicians do not receive feedback from the case and are not given the opportunity to close any medical holes which may exist. Many physicians want to change that.

The task force will invite judges, prosecutors, defending attorneys, Child and Youth Services agents, and others involved in the process of child abuse detection and follow-up to participate in the conference. Each will tell "their side of the story," and all will work together to design improvements to the system. The topic of religious exemptions of child abuse is also a concern of the task force. The ideal outcome of these efforts and others by the task force will be educational programs and legislation addressing the issue and the process.

COALITION TO ADDRESS SCHOOL HEALTH PROGRAMS

The State Society is helping to formalize a coalition, in existance informally for several years, which seeks to mandate stronger school health education programs throughout Pennsylvania. Current law directs that each school district design its own curriculum.

After initial organizational meetings, the coalition will use guidelines for health education, such as those published by the Centers for Disease Control, to address what education is necessary to help students live a healthy lifestyle and protect themselves from pregnancy, disease, etc. The coalition will also seek support and sponsorship of legislation from state policymakers, and lobby for passage of legislation mandating details for such programs.

The group's steering committee, which met in February to begin the formalization process, includes representatives of several health care and education groups, and intends to broaden that base of support.

CRISIS TEAMS RESPOND TO ADOLESCENT PROBLEMS

In recent years, the number of children aged 10-19 who have committed suicide has led schools to take a more active role in prevention, intervention, and tragically, post-vention. Many schools across the country have addressed suicide and other crises facing youth and educators by using crisis response teams.

The response teams consist of school staff trained to handle student crises and usually include representatives from administration, counseling, social work, and teaching and support staffs. Psychiatrists from the community may also serve as outside consultants. The teams are used to handle events that impact the entire school population and crises affecting single students. The goal of intervention is to prevent and replace self-defeating or self-destructive behaviors with effective coping skills which can reduce anxiety and enhance students' ability to manage in the future.

Taken from "Target 2000: A Newsletter of the AMA Healthier Youth by the Year 2000 Project."

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March 1992

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Chief Resident, Department of Medicine
Hahnemann University
Cathy Jensen, MD
Chief Resident, Department of Medicine
Hahnemann University
Richard Maniglia, MD
Chief Resident, Department of Medicine
Hahnemann University
Jay Patel, MD
Chief Resident, Department of Medicine
Hahnemann University

March 11, 1992

CARDIOLOGY - ISSUES AND ANSWERS FOR THE 90's
Sylvan L. Weinberg, MD
Clinical Professor of Medicine
Wright State University
Dayton, OH

March 18, 1992

OCULAR MANIFESTATIONS OF AUTOIMMUNE DISEASE
Stephen Sinclair, MD
Professor of Ophthalmology
Vice Chairman, Department of Ophthalmology
Hahnemann University

March 25, 1992

HYPERTENSIVE NEPHROSCLEROSIS: IS IT BENIGN?
Jerome Porush, MD
Professor of Medicine
SUNY Health Science Center
Chief, Nephrology and Hypertension
Brookdale Hospital and Medical Center
Brooklyn, NY

April 1992

April 1, 1992

CURRENT CONTRACEPTIVE MANAGEMENT: BENEFITS AND RISKS
Richard A. Baker, MD
Professor and Vice Chairman
Department of Obstetrics and Gynecology
Hahnemann University

April 8, 1992

PRINCIPLES GOVERNING THE USE OF THROMBOLYTIC AGENTS
Burton E. Sobel, MD
Lewin Professor of Medicine
Director, Cardiovascular Division
Washington University School of Medicine
St. Louis, MO

April 15, 1992

INTRAVASCULAR CATHETER-RELATED INFECTIONS
Dennis G. Macki, MD
Professor of Medicine
Chief, Section of Infectious Diseases
University of Wisconsin Medical School
Madison, WI

April 22, 1992

NUTRITIONAL SUPPORT IN THE CRITICAL CARE UNIT
Rosemarie L. Fisher, MD
Associate Professor of Medicine
Division of Digestive Diseases
Department of Internal Medicine
Yale University School of Medicine
New Haven, CT
ENDOSCOPIC MANAGEMENT OF BILIARY TRACT DISORDERS
Jerome H. Siegel, MD
Associate Professor of Medicine
Mt. Sinai School of Medicine
Chief, Endoscopy Unit
Beth Israel Medical Center North
New York, NY

April 29, 1992

DEVELOPMENT OF SKIN SUBSTITUTES
Richard L. Spielvogel, MD
Professor of Medicine and Dermatology
Director, Division of Dermatology
Hahnemann University

May 1992

May 6, 1992

HYPERTENSION IN PREGNANCY
Robert W. Schrier, MD
Professor and Chairman
Department of Medicine
University of Colorado School of Medicine
Denver, CO

May 13, 1992

INVASIVE VERSUS NONINVASIVE ASSESSMENT OF VALVULAR HEART DISEASE
Richard Gorlin, MD
Professor and Chairman
Department of Medicine
Mt. Sinai School of Medicine
New York, NY

May 20, 1992

PARANEOPLASTIC ENDOCRINE SYNDROMES
Kenneth L. Becker, MD, PhD
Professor of Medicine and Physiology
Director, Division of Endocrinology
George Washington University Medical Center and VA Medical Center
Washington, DC

May 27, 1992

GUILLAIN-BARRE-STROLLE SYNDROME
Michael Sherman, MD
Assistant Professor of Medicine
Director, Pulmonary Function Laboratory
Division of Allergy, Critical Care & Pulmonary Medicine
Hahnemann University

Seth Tarras, MD
Assistant Professor of Neurology
Director, EMG Laboratory
Director, ALS Center
Department of Neurology
Hahnemann University

Scott Hessen, MD
Assistant Professor of Medicine
Clinical Electrophysiology Laboratory
Likoff Cardiovascular Institute
Hahnemann University

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Tuberculosis of the 1990s: The Quiet Public Health Threat

Richard T. Bell, MD

Therapeutic advances over the last four decades have led to a significant reduction of new cases of *Mycobacterium tuberculosis* (TB) and allowed nearly 600 sanatoria to close in America. The number of active cases of TB in 1984 decreased to nearly 25 percent of those reported in 1953. It appeared that the U.S. was headed toward a utopian state of total control or even elimination of TB. However, geopolitical, socioeconomical, and medical factors contributed to an increased TB incidence altering this lofty hope.

The emerging problem for the 1990s is the resurgence of tuberculosis (TB) and its rising mortality rate. More ominously, the number of difficult-to-treat patients and infections by multiple drug-resistant TB organisms is increasing. These problems are avoidable since TB has been treatable and preventable for nearly 40 years.

The introduction of isoniazid (INH) in 1952 and rifampin in 1971 provided the modern, combined intracellular and extracellular bactericidal anti-tuberculous therapy which covered all phases of a TB infection. Pyrazinamide (PZA) is bactericidal only in the intracellular phase, while the rarely used streptomycin and kanamycin are bactericidal in the extracellular environment. The remainder of the second-line medications are bacteriostatic and less therapeutically effective.

The development of organism resistance is an independent event for each TB drug occurring spontaneously at a rate of one in 10^5 to 10^6 bacilli. In the U.S., only seven percent of TB organisms are resistant to one or more of the drugs. Because large TB cavities involve approximately 10^8 to 10^9 organisms, statistically there are many drug-resistant mutants in a severe infection. Thus, there is a small therapeutic cushion for the spontaneous development of resistance to two TB drugs which has an occurrence probability of $10^6 \times 10^6$ or 10^{12}.

Even if these odds are beaten, the Darwinian drug-resistant organisms still can be controlled and eradicated with careful treatment monitoring. TB bacteria may be eliminated by alveolar macrophages before a lesion is produced. Despite optimum TB therapy and compliance, there is still a small chance of the development of a drug-resistant TB infection.

During the '60s and '70s, the U.S. experienced an influx of refugees from Asia, Africa, and Latin America. Because of casual INH use and poor medical care in their homeland, these high TB-prevalence peoples may have a 20 percent incidence of primary INH resistance TB. A low socio-economic status is associated with a higher-than-expected TB mortality. Crowded living conditions are a major etiology in TB communicability.

Since most of these new American citizens became urbanized poor, living at poverty levels in high-density housing units, multiple factors create a significant TB risk. In fact, 22 percent of the reported TB patients in 1988 were foreign born, with over half having arrived within the previous five years. Furthermore, many immigrants had language barriers which limited their access to quality health care.

Complicating effective TB control programs are the indigent and medically underserved, including the increasing numbers of individuals who are homeless or substance abusers or HIV positive. These individuals are generally less compliant with the treatments provided. Nationwide, more than 17 percent of patients do not take their TB medication continuously, and 25 percent do not complete the recommended course of therapy. With unmonitored stops and starts of TB therapy, progressively more resistant organisms develop. Patients will become lost to follow-up if their treatment is not carefully supervised.

Governmental economics compound the problem with diminished funding for surveillance and treatment of TB. With the demise of the sanatoria, there is a lack

"Governmental economics compound the problem with diminished funding for surveillance and treatment of TB."

Dr. Bell is president of the Pennsylvania Society for Pulmonary Medicine.

of designated facilities to care for the difficult-to-treat TB patients.

In 1950 a concerted effort by the pharmaceutical industry to develop effective anti-tuberculosis medication led to the release of INH within two years. Since concern for TB was diminishing until recently, there has been little aggressive pharmacological research to develop new TB chemotherapy. This research is felt by some not to be cost effective or a high priority.

Active TB may go undetected for years, because its symptomatic presentation may be subtle. Nearly five percent of the TB cases are first reported at time of death. Thus, the most important element in TB control is the detection with PPD testing of high-risk patients and treatment of infected patients with INH before significant disease emerges. With the declining incidence, there are new generations of physicians who have not diagnosed many TB cases. This unfamiliarity contributes to a decreased clinical suspicion and delayed detection, producing more advanced and contagious cases.

The changes in TB chemotherapy over the past decade have left many physicians less proficient in TB management. Treatment errors, such as adding only one new drug at a time to a failing treatment, could lead to the rapid development of a drug resistance.

With medical advances, critically ill and chronically moribund patients are surviving longer and developing immune impairment which produces more susceptible hosts. Stable granuloma may reactivate a TB infection by breaking down during a prolonged illness and releasing previously dormant TB organisms. Individuals who had inadequate TB therapy have experienced a yearly reactivation rate of one percent and represent about 90 percent of the newly active cases in the U.S.

The HIV epidemic is contributing to a dramatic increase in TB. The primary immune defect (T-cell lymphocyte depletion) in HIV infection makes the host unable to effectively combat a mycobacterium infection. Because of the large numbers of uncontrolled TB organisms, there is an increased infection risk for the caregivers who have prolonged close contact with the infected patient.

There is no natural immunity or consistently effective mass immunization against TB. This places the burden on the doctor to be vigilant for the presence of TB in a diverse group of high-risk patients. If a practitioner is unfamiliar with recent TB treatment guidelines, it is prudent to involve an experienced physician in the patient management. State Health Department offices can provide assistance with advice and possibly defray some or all treatment costs.

A recent report of 13 people dying of drug-resistant TB in New York may represent only a minor outbreak compared to potential problems in the future. Even though the index case emanated within the penal system, this occurrence is not an aberration. In Pennsylvania, difficult-to-treat patients with documented drug-resistant TB have infected others. Unfortunately, there have been problems in adequately caring for these patients, despite efforts of the American Lung Association of Pennsylvania and concerned physicians.

Physicians should review the latest TB surveillance and treatment recommendations, which have changed dramatically over the past 10 years. To facilitate this, county and hospital CME programs could present an update of TB as a timely topic. New bactericidal TB medications need to be developed to effectively treat drug-resistant infections. Patients must be effectively isolated during the communicable period of their disease until they are no longer a hazard to society. Furthermore, there must be increased cooperation with the Pennsylvania Department of Health to provide adequate care of potentially serious communicable cases. We cannot afford a return to the state of ineffective, but well-meaning, TB treatment prior to the introduction of INH.

New Guidance Expands Documentation Requirements

Donald E. Harrop, MD

Like the real estate salesman who evaluates property on the basis of three factors—location, location, and location—representatives of the Keystone Peer Review Organization (KePRO) preach *documentation, documentation, documentation.*

Legislation and directives from the Health Care Financing Administration (HCFA) have led to two situations in which proper documentation of patient records can save physicians time and effort required to research and draft a response to a question from the Keystone Peer Review Organization (KePRO).

In the first situation, the actual responsibility lies with the hospital. The legislative initiative known as the Federal Patient Self Determination Act became law on December 1, 1991. The Act requires hospitals during admission to ask patients, or their representatives, whether any advance directives are to be followed in the event of terminal illness, permanent unconciousness, or another situation in which the patient is unable to communicate his or her wishes. As you can well understand, *the existence of these advance directives could have an important bearing on KePRO review decisions in certain cases*.

Documentation of such directives can be extremely helpful to KePRO reviewers in understanding the level of care established for and provided to terminally ill or unconscious patients. Although the mandate of this law applies to hospitals, it behooves physicians to be sure that appropriate documentation of a patient's wishes, or those of his or her representatives, is contained in the medical record in order to avoid having to subsequently clarify the reasons for certain clinical decisions and actions.

In the second situation, a HCFA directive applies to Medicare patients and directly involves PROs. PROs must monitor the existence of patient consent forms, which are to be properly executed prior to the performance of invasive procedures. HCFA has directed PROs to verify the existence of these forms in cases involving such procedures. It is now a HCFA requirement *that the absence of either a form, or a reference indicating that a consent form had been completed, is considered a quality problem*.

In compliance with the HCFA directive, KePRO has included verification of appropriate documentation of patients' or their authorized representatives' consent forms for invasive procedures as part of the standard review process. Physicians should keep in mind that when the absence of properly executed consent forms is discovered as part of the review process, both the hospital and the operating physician must be held accountable for the quality problem.

Even without these additional requirements, there are clearly sufficient reasons for physicians to be aware of the contents of patient medical records and assure their completeness. Like the proverbial "apple a day" which "keeps the doctor away," proper and adequate documentation will usually obviate the need for KePRO to request additional information.

Dr. Harrop is president of the Keystone Peer Review Organization.

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The Problems of Water Pollution: An Overview

George Lumb, MD, MRCP, FRCPath
Anthony S. Clare, PhD, MS

Most potentially toxic chemicals eventually find their way into waterways. The most common source of this pollution is from the air. More than 50 percent of the chemical pollution of the Great Lakes is believed to come from airborne pollutants, and the main sources of this pollution are smokestacks (energy plants, nuclear or conventional; trash-to-steam incinerators; industrial factories, chemical and wood pulp) and road traffic exhaust. Chemicals may reach waterways directly through partially filtered or untreated sewage and waterway traffic, both industrial and pleasure; or they may be deposited into the soil and reach rivers and estuaries through leakage (PCBs on cables, landfills, and regular or low-level nuclear waste) or locally from fields (fertilizers, herbicides, phosphates, and other chemicals).

The variety and number of potentially toxic substances are enormous, including such obvious ones as heavy metals and their compounds (i.e. nickel, chromium, mercury, cadmium, copper, and lead); sulfur dioxide (acid rain); dioxins; and complex organics (fertilizers, herbicides, and phosphates).

It is unrealistic to suggest eliminating all these substances entirely. However, techniques for reducing their quantities to the lowest possible levels compatible with industrial requirements and human and ecological safety must continue to be improved.

The problem of waterway pollution poses dangers not only directly to people swimming or drinking the water, but also to the ecology, especially fish, crustaceans, water fowl, birds, trees, and plants. Pollution affects not only living organisms, but also, indirectly, humans who need fish and crustaceans for food. Of equal importance are industries such as fishing, housing and industrial development, and farming. Farmers are pressured to diminish the amount of fertilizers and herbicides they use to develop crops, but are not given any specific safety levels. This causes great frustration, particularly among large development farmers whose land is adjacent to rivers or estuaries. In the past few years, many such farmers have sold their lands to industrialists or developers, which increases the problem by introducing factories—particularly wood pulp and paper factories—and houses, hotels, and other potential sources of pollution.

Measuring chemical levels and other parameters such as water temperatures and pH levels, estimating fish kills, and studying gross abnormalities in fish and crustaceans under reasonably well-controlled conditions are valuable but not accurate enough to establish no-effect levels (NOELS) or safe levels for complex mixtures. Attempting to apply toxicity or carcinogenicity results obtained in mammals (mostly rats and mice) to fish and crustaceans is quite unsatisfactory. Most classic toxicology and carcinogenicity studies in rats and mice are being severely criticized in terms of their value of application to humans.[1]

It is generally recognized that alternate models to these tradional ones are urgently required. Many scientific problems must be overcome in order to provide meaningful information on danger levels of extraneous substances in water systems. However, regulatory anomalies exist with regard to water contamination control which confuse communications between authorities. To the scientist, the interrelationships between air, groundwork, rivers, estuaries, and oceans seem evident. Yet, regulatory groups control each of these parameters, and communication between them is minimal or in many cases non-existent. The observations and regulations provided by various authorities are sometimes even contradictory. Influence from political and in-

Dr. Lumb is a scholar in residence at the Department of Pathology, Integrated Toxicology Program, of Duke University, and professor of pathology emeritus at Hahnemann University. Dr. Clare is research assistant professor at Duke University Marine Laboratory.

dustrial needs plays a large part in the decision making, rather than accurate scientific safety levels.

Of particular importance are human and animal health problems related to the use of herbicides and pesticides, because of agricultural development. Information is conflicting, and procedural recommendations cannot be made without much more research.

The most frequently used herbicides worldwide are the phenoxyacetic acids and chlorophenols. The two most frequently discussed are 2,4-dichlorphenoxy-acetic acid (2,4-D) and 2,4,5-trichlorophenoxyacetic acid (2,4,5-T). The chemical 2,4-D is generally regarded as free from toxic or malignant potential for humans. A recent report from Canada confirms this view.[2]

The chemical 2,4,5-T contains a contaminant known as 2,3,7,8-tetrachlorodibenzo-p-dioxin (2,3,7,8-TCDD), commonly called dioxin. It is both an air and water pollutant, produced by combustion from all sources. It emerges from all smokestacks, including those of electrical and nuclear power stations, as well as the so-called trash-to-steam incinerators. It is therefore deposited in groundwater and all water sources, from lakes and rivers to the ocean. It is considered by the Environmental Protection Agency (EPA) as the most serious air and water contaminant.[3]

Dioxin came into prominence when scientists realized that one of the components of the ill-famed "Agent Orange" used as a defoliant in the "Ranch Hand Exercise" during the Vietnamese War was 2,4,5-T with the associated dioxin as contaminant. Dioxin is important not only as a potential hazard but also as an example of the need for more adequate models for the study of ecologic (including human) dangers. It is extremely toxic in rats and lethal at extremely low doses, so that "maximum tolerated doses" (MTDs) cannot be achieved. The only reasonably meaningful carcinogenicity study showed malignant tumors at a dose of 0.1 ug/kg in rats. However, at that dose level, toxic manifestations were numerous,[4] making assessment of validity difficult.

Follow-up of workers exposed to high levels of contamination at the time of industrial explosions shows that human tolerance is quite high. One of the few well-documented lesions is an unpleasant chronic dermatitis known as chloracne.[5,6] The toxicology of TCDD (dioxin) has been reviewed in detail elsewhere.[7]

Experimental studies of agricultural workers exposed to herbicides and pesticides over long periods have shown evidence of an increased incidence of Non-Hodgkin's lymphoma (NHL).[8,9,10,11] However, it is very difficult to assign a specific chemical as the causative toxic substance, as all of the workers were exposed to a number of different chemicals, including, in some cases, chlordane. (It should be noted that chlordane and 2,4,5-T are no longer marketed in the United States.) A recent, excellent, and long-term follow-up review of cancer mortality among workers exposed to dioxin (TCDD) shows only equivocal relationship.[12] An editorial on the same subject reaches similar conclusions.[13]

Dumping in oceans and estuaries

Using the oceans as depositories has been considered by many scientists as a reasonable solution for waste disposal, with the idea that dilution would reduce the impact of pollutants below a dangerous level.[14,15,16,17]

In recent years, the volume of garbage dumped, overfishing, oil spillage, and leaks from underwater drilling have shown clearly that this natural resistance can be overcome. Twelve miles offshore into New York Bight, which was a "permitted area" for dumping, is now heavily polluted, and a new area was identified 106 miles offshore in 1987.[18] This is distant from coastal fisheries and recreational areas, but water and sediment dynamics must be studied in much greater detail before giving a blessing to this new area. The alarming appearance of garbage along the New Jersey shoreline further shows that all is not well.

The problems in estuaries are similar to those in oceans. In such areas, industrial facilities, farmland, housing developments, and marinas are the principal pollution sources. The dangers are increased by the fact that many marine creatures enter estuaries to join the natural inhabitants during reproduction periods. The study of these matters is in its infancy, and research programs must be set up to establish mod-

els to deal with ecologic toxicology for its own sake and for its impact on humans.

The alternative to dumping waste material in the oceans is to develop satisfactory methods of disposal on land. Household refuse and material from industrial sites and other areas contain a large variety of waste products. Many of these, and in particular human and animal excreta, could be transformed into valuable manure and fertilizer. The problems of handling waste material can, to a large extent, be diminished by careful separation of components and recognition of the feasibility and value of recycling.

To make such a system successful, it is essential that waste be handled carefully at its source, whether household trash, sewage, or trash from large institutions, particularly hospitals and laboratories. Waste must be separated into obvious categories such as paper, bottles, and known toxic substances, especially by certain factories, hospitals, and laboratories. Materials must be clearly labeled for the collection agencies.

Once this separation has been achieved, the recycling methodologies are well understood. It is encouraging to see this method of handling waste products beginning in many parts of the country. As people become accustomed to doing relatively simple separation procedures, the problems of pollution will be enormously influenced. However, this done alone can never entirely cure the problem, as some of its advocates maintain, anymore than it is a useless procedure, as the advocates of other methods of dealing with waste material such as "trash-to-steam" incinerators, would recommend.[19]

Test procedures

State-of-the-art toxicity testing of chemicals that either directly or indirectly impact humans relies to a large extent on the use of animals. These have, as already stated, been applied to the ecology of rivers and estuaries somewhat unsuccessfully. In recent years there have been attempts to develop alternative toxicity testing procedures. Most of these new techniques permit screening studies to be performed and, as a consequence, contribute to a reduction in the number of animals in use. The new techniques and those under development are to a large extent variations of the methodology of *in vitro* toxicity testing. Exceptions are the newer microbial toxicity assays where the whole organism is used.[20]

In vitro toxicity testing affords the advantage of relatively low cost coupled to speed, but suffers the drawback of difficulty in extrapolating to effects in the complex whole organism. A new model must be representative of the ecosystem and must provide dose levels of the toxic effects, in addition to NOELS for substances which can be tolerated. If a NOEL cannot be established, such a substance or chemical must be prohibited from the ecosystem.

Tumor formation, mostly liver malignancies, have been documented in a number of fish (winter flounder, rainbow trout) which have been exposed to pollutants. These have been suggested as biomarkers. The disadvantages of using tumor formation as a biomarker are that only one parameter of toxicity is studied, experiments are lengthy, and most of the problems of interpretation already encountered with mammalian tumor models can be anticipated. A more general model type would, therefore, be an advantage.

Researchers at Duke University Marine Laboratories are investigating an invertebrate model, using the ability for limb regeneration following autotomy in the megalope stage of the juvenile mud crab (Rhithropanopeus harrisii). The reasons for this are several-fold: 1) the mud crab is a common estuarine organism and has a wide distribution; 2) the biology of R. harrisii and related crabs has been studied extensively; 3) the adult crabs are easily maintained in the laboratory, and optimal conditions for complete larval development have been established; 4) although a seasonal breeder in the field, reproduction and development can be manipulated in the laboratory so that animals are available throughout the year; 5) they can be maintained in artificial sea water, making them available to land-locked research facilities; 6) tissues/organs are readily accessible, and in the larval stages, observations of internal organs can be made through the transparent exoskeleton; 7) many of the organs have counterparts in vertebrates in terms of structure and/or function (for example, the midgut gland is related to the liver, the gills to the lung, and the central ganglia to the brain); 8) the small size, especially of the larval and juvenile forms, enables large numbers of known parentage to be maintained (thousands may be kept in a small environmental cabinet) allowing critical statistical analyses; 9) the cost is low; and 10) development is rapid, especially of the larval stages (development of the egg to the adult takes weeks rather than the months/years for vertebrates; thus, complete life-cycle and multi-generation studies are practicable).

A sublethal bioassay has been developed.[21] The first step in the procedure is

to induce megalopae to autotomize a cheliped. Autotomy is a defensive mechanism whereby an appendage is shed, with little or no loss of body fluid, and occurs invariably in response to seizure by a predator. Subsequent regeneration of the limb is then monitored in the presence of toxicants at the gross morphological level. Thus far, the bioassay has been used to test a number of pesticides and a herbicide. Certain chemicals, notably carbamate insecticides, have been found to be teratogenic in this assay, in that they either inhibit regeneration, or the regenerate that forms is abnormal in terms of size and/or morphology. It may be of significance that carbamate insecticides are also teratogenic to vertebrates. In fact, there is a general correlation between chemicals that are teratogenic to aquatic animals and those that are teratogenic to humans.[22] Carbamates and organophosphate insecticides are teratogenic to humans. Carbamates and organophosphate insecticides are teratogenic in vertebrates by virtue of their ability to lower levels of NAD. ATP and energy levels of cells are also reduced. Administration of NAD counteracts the teratogenic effects.[23]

Possible mechanisms of teratogenesis in crabs include abnormal cell or tissue differentiation, inadequate cell migration, improper cellular communication, and disrupted metabolism. As a first step in resolving this issue, we have studied the normal process of cheliped regeneration at the ultrastructual level.[24] We propose to continue further studies with tissue culture and immunohistochemical procedures with certain cells and structures appearing in the normal regenerative process. At the same time, we will proceed to toxicologic assays to establish dose-effect levels on the regenerative process and to investigate NOELS which can be translated to *in vivo* experiments in the ecosystem.

The mud crab regeneration assay is perceived as being just one component of a potential battery of such assays. The assays, which ideally should be disparate in their sensitivity of different effects of pollutants, may be used as *in situ* assays.

The current state-of-the-art techniques for the placement of such assays rely to a large extent on intuition. For example, in the placement of assays at a site of sediment contamination, the data available will invariably have been obtained from chemical analyses of sediment cores. But what is the rationale behind the choice of core locations?

A common assumption (which may be reasonable in some instances) is that sediment contamination is associated with point sources, and the design of core sampling sites reflects an assumed gradient of decreasing contamination away from the point source. This design is clearly unsatisfactory in a dynamic situation, such as an estuary, where sediment transport is an

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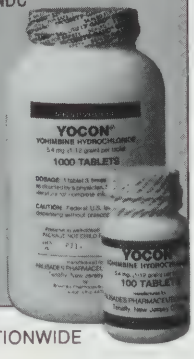
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obvious influencing factor. Another factor to be considered is that sediment toxicity displays considerable spatial variability. This factor is of importance when biological effects are to be considered. Sediment that displays toxicity at one point may not be toxic at a point only a few meters away. The poor resolution obtained from a typical core sampling survey is thus a limiting factor in siting *in situ* biological assays.

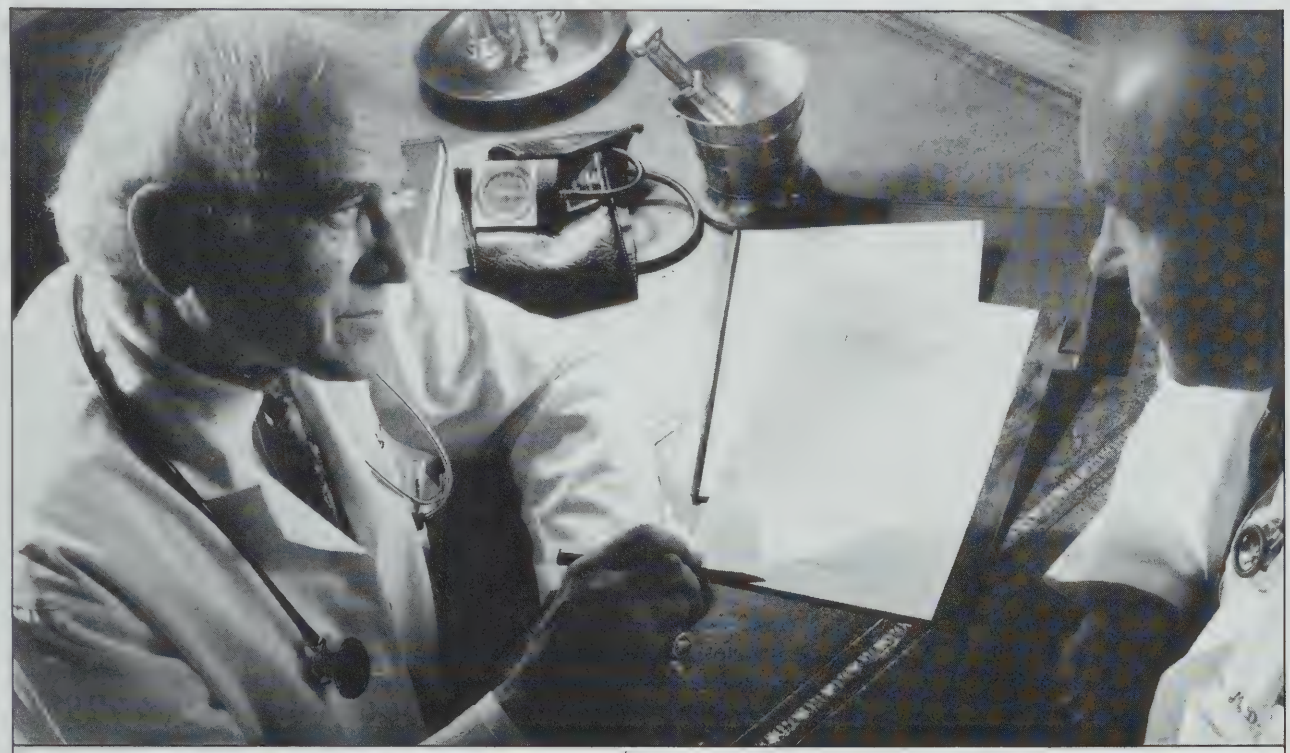
In collaboration with colleagues at University of Georgia and East Carolina University, researchers at Duke have evaluated a technology developed for mineral exploration on the continental shelf.[25] We have tested one component, the "gamma sled," of a two-component system. The gamma sled is essentially a gamma detector housed in a towable sled. The signal from four NaI detectors is amplified and fed on board ship via a coaxial cable. Under field conditions, this technology has proven applicable to estuarine sediment surveys, providing real-time data on sediment contaminants.[26] The researchers are also evaluating biological assays that are capable of providing rapid data on sediment toxicity, the aim being to fine-tune the placement of the batteries of biological assays. Taken together, it is believed that this technology has the potential to revolutionize the way that estuarine sediment surveys are performed.

Most scientific investigations about the complex problem of water pollution are in the developmental stage. Until these are established, separating identified toxicants and recycling effectively can help diminish these serious problems for today.

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New Trustees Discuss Health Care Reform

Maria T. Montesano
Assistant Managing Editor

This second of three articles profiling the State Society's newly elected trustees features James R. Regan, MD, Interspecialty Section, and William R. Beltz, MD, Seventh District.

The upcoming presidential campaign will assuredly interest physicians across the nation as candidates present their views about national health care reform. This series of interviews with newly elected State Society trustees has provided a similar forum for these physicians' views on not only the reform issue, but also many others facing medicine today.

The professional

James R. Regan, MD, has been involved in organized medicine for more than 22 years, first through the Pennsylvania Society of Internal Medicine and then through the Pennsylvania Medical Society. As the newest trustee representing the State Society's Interspecialty Section, he hopes to guide the Society into added public health efforts and increased professionalism.



Dr. Regan

Dr. Regan graduated in 1956 from Jefferson Medical College of Thomas Jefferson University and completed his internship at Geisinger Medical Center. He then served four years in the U.S. Air Force in Oklahoma before returning to Jefferson for four years of resident training. A specialist in internal medicine, he has been in private practice in Bethlehem since 1964.

"I enjoyed my time at Jefferson, especially the last two years in the academic training program. I had a lot of fun," he says. He speaks fondly of his early years in each new career area he pursued: "The first year of my experience in the Air Force was a nice change. I had never had any outpatient experience, and that was an interesting challenge...and I particularly enjoyed my first few years in private practice...I saw interesting patients, they were challenging, and I enjoyed it immensely." He admits that medicine has now "lost a little of its lustre" for him, but says he still enjoys being a physician.

Dr. Regan was initially reluctant to become involved in organized medicine, but was impressed with the orderly proceedings and attendance of prominent physicians at his first House of Delegates meeting. He gradually became more involved, by serving as a member of Society committees and of the Interspecialty Section for several years, eventually as chairman. Today, he describes the development of professional relationships through organized medicine as a "personally enriching experience" and the knowledge he acquired as "educational and informative."

He pursued the trustee position because "there are some things I would like to see done for the Society that I thought I might be able to achieve...my thrust will be to try to regain some of the lost professionalism and respect that physicians had many years ago." To achieve that would help solve the most important issue facing physicians today, he says: the intrusiveness of outside parties upon the practice of medicine. "I practice a good deal of geriatric medicine, and I now am directed by federal legislation, through OBRA, very specifically about how I should treat patients in nursing homes concerning certain drugs. I consider that a terrible intrusion, and I view it as something that is just beginning."

As chairman of the State Society Board of Trustee's Committee on Long-Range Assessment, Dr. Regan is also closely involved with defining Society policy on health care reform. "The committee is in

the process of formulating those thoughts...I don't have concise answers," he says, "but I can tell you that reform *is* essential...We may have common payors, we may have managed care, we may have many new styles of practice, but what we must not have is a government-administered health care system." He adds, "The government is a player and should be...but it must not be *the* player."

The emigrant

William R. Beltz, MD, the Society's new Seventh District Trustee, is an Illinois native who chose to live in the Keystone State "on one of those bright, clear days in mid-October when red and gold leaves were everywhere." Now a resident of Pennsylvania for 12 years, he is a general surgeon who also performs vascular surgery. The ABC Wide World of Sports slogan, "the thrill of victory, the agony of defeat," invokes images of the practice of medicine in Dr. Beltz's mind: while there are "tough problems" in medicine, he feels a sense of satisfaction from his work.



Dr. Beltz

Dr. Beltz graduated from the University of Missouri and decided to go to medical school "fairly late" in his college career. He received his medical degree from the University of Illinois in 1970 and completed his residency at Duke University Medical Center in Durham, North Carolina. He then served for three years on the faculty at The Milton S. Hershey Medical Center.

Dr. Beltz joined the State Society in 1978 but admits that he was "never really involved in organized medicine until about 1983 or 1984, when I became a delegate to the House." He enjoyed that involvement so much that he became a member of two councils: those on medical economics and governmental relations. "Several people encouraged me to run for the trustee position," he says, and he did so believing organized medicine "is the only place where the voice of a physician, practicing day-to-day in a community, can be heard."

"I think the most important issue facing physicians today is the loss of autonomy in making clinical decisions about their patients," Dr. Beltz says. He cites pre-admission certification and upcoming practice parameters as examples of changes affecting loss of autonomy, and he urges organized medicine to become involved in developing practice parameters: "Whether they will be intelligently done—or how intelligently done—remains to be seen."

During this election year, heated debate about national health care has already begun. When asked to comment, Dr. Beltz says: "I don't know the answer to the problem. I *do know* that when you talk to a family of three—all healthy and he's out of work—and to continue their health insurance, they have to pay $425 a month, that's probably not acceptable."

He hopes policy makers don't do something "hasty" without working through the issue: "I think it's going to take a lot longer than people expect to hammer out the issue, because people are just now seriously considering all the options rather than just saying they are *for* national health insurance. That's not enough."

In the future, Dr. Beltz would "like to see the Society develop into the primary source for accurate health care information in the state...the source that everybody goes to." Society actions are instrumental to the future of medicine in Pennsylvania, he says: "What we do in the next five years will plot the course for the next 15."

"What we do in the next five years will plot the course for the next 15."



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Laboratory Tests—False-positive tests for urobilinogen with Multistix® may occur during therapy.

Drug Interactions—No interactions have been observed with theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility—A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups.The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Worldwide, controlled clinical trials included over 6,000 patients given nizatidine in studies of varying durations. Placebo-controlled trials in the United States and Canada included over 2,600 patients given nizatidine and over 1,700 given placebo. Among the adverse events in these placebo-controlled trials, only anemia (0.2% vs 0%) and urticaria (0.5% vs 0.1%) were significantly more common in the nizatidine group. Of the adverse events that occurred at a frequency of 1% or more, there was no statistically significant difference between Axid and placebo in the incidence of any of these events (see package insert for complete information).

A variety of less common events were also reported; it was not possible to determine whether these were caused by nizatidine.

Hepatic—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

CNS—Rare cases of reversible mental confusion have been reported.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of anti-androgenic activity due to nizatidine. Impotence and decreased libido were reported with similar frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic—Anemia was reported significantly more frequently in nizatidine than in placebo-treated patients. Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H_2-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental—Urticaria was reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity—As with other H_2-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. The ability of hemodialysis to remove nizatidine from the body has not been conclusively demonstrated; however, due to its large volume of distribution, nizatidine is not expected to be efficiently removed from the body by this method.

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Additional information available to the profession on request.

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26th Annual Main Line Conference

Thursday, Friday and Saturday

April 9, 10 and 11, 1992

THE AMERICAN COLLEGE
BRYN MAWR, PA

Sponsored by
THE BRYN MAWR HOSPITAL
In affiliation with Jefferson Medical College

GUEST SPEAKERS

Donald O. Castell, MD
Professor of Medicine and
Director, Division of
Gastroenterology and
Hepatology
Jefferson Medical College

Suzanne D. Fields, MD
Chief, Geriatric Section
St. Vincent's Hospital
New York

H. Howard Goldstein, MD
Lecturer in Medicine
Harvard Medical School

Marc C. Hockberg, MD
Professor of Medicine
Epidemiology and
Preventative Medicine
University of Maryland
School of Medicine

Lawrence J. Mellon, MD
Clinical Assistant Professor
of Preventative Medicine
(Adjunct)
Jefferson Medical College

Joel L. Schwartz, MD
Assistant Medical Director
and Director of Child and
Adolescent Services
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PROGRAM INCLUDES:

- Arthritis Management
- Colon Cancer
- Diabetes
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- Skin Lesions
- Surgical Office Procedures
- Syncope
- Plus 24 Concurrent Clinics

REGISTRATION FEE: $275.00
(includes 3 luncheons and 1 dinner with cocktails)

FOR INFORMATION WRITE:
Harold J. Robinson, MD
Director, Main Line Conference
The Bryn Mawr Hospital
Bryn Mawr, PA 19010

ACCREDITATION:

AMA
As an organization accredited by the Accreditation Council for Medical Education (ACCME) for its continuing medical education program, Jefferson Medical College designates this activity as meeting the criteria for 21 credit hours in Category 1 of the Physician's Recognition Award of the American Medical Association.

AAFP
This program has been reviewed and is acceptable for 21 Prescribed hours by the American Academy of Family Physicians.

GOVERNOR PROPOSES $9.9 BILLION DPW BUDGET

Governor Robert Casey has proposed a $9.9 billion budget for fiscal year 1992-93 for the Department of Public Welfare (DPW). State funds total $4.8 billion, a nearly five percent increase from 1991-92; and $5.1 billion comes from federal and augmentation dollars.

Medical Assistance

Total state funding for Medical Assistance (MA) programs will increase by 11 percent to a total of $2.1 billion in 1992-93, according to the proposed budget. DPW is expecting a 6.8 percent growth in the number of individuals qualifying for and using MA services.

Funding is also included to provide for the outpatient fee increases approved during the current fiscal year. Approximately $19.8 million in state dollars is budgeted for new programs, including non-hospital drug and alcohol services, special drugs for people with AIDS or schizophrenia, and early childhood immunizations.

Several cost-cutting measures have been proposed to preserve the MA program "without making wholesale cuts in services," according to DPW. These include:

- providing basic health coverage for the general assistance population;
- developing additional capitation programs similar to the HealthPass program used in Philadelphia;
- controlling allowable nursing home costs;
- employing better management techniques for existing programs; and
- expanding the prior authorization requirement for various medical techniques.

DPW anticipates that such cost-containment measures will save the state more than $87.7 million in the coming year.

Healthy Beginnings

The Department's proposed budget includes $7.2 million in state funds to expand eligibility for the Healthy Beginnings program, initiated in 1988. The program provides prenatal and preventative health care to low-income pregnant women and their children who otherwise would have no health insurance. DPW says an expansion will extend benefits to an additional 12,600 pregnant women and 12,100 infants in 1992-93.

DOH BUDGET INCLUDES MAJOR PROGRAM REVISIONS

The governor has included several major program revisions in his 1992-93 proposed budget for the Department of Health (DOH). The revisions strive to improve access to care problems and funding for HIV/AIDS initiatives.

Five million dollars has been budgeted through a Family Practice Incentive program to aid in access to care problems created by a decline in family practice physicians. According to DOH, the proposed program "is designed to encourage medical schools to train family practice physicians and to offer students training rotations in underserved areas." Under the program, state funds will be made available to medical schools to develop and promote programs to meet that objective.

Also, more than $1 million has been suggested to expand HIV/AIDS services. The governor proposes $925,000 in state monies and $100,000 in federal monies to fund DOH's four-part program revision. The monies would be dispersed as follows: $360,000 for foundation building; $400,000 for CD4 (white blood cell) testing at selected sites; $165,000 for training and clinical help for health care workers; and $100,000 for HIV prevention and early intervention services for women and children.



In an effort to warn against linking the state workers' compensation system to the federal Medicare system, the State Society held a press conference on January 28 in the Capitol in Harrisburg. Society President Robert N. Moyers, MD (at podium), called upon the Senate to reject the Medicare tie-in and consider an alternative developed by the Society in cooperation with the Hospital Association of Pennsylvania.

CHILDREN'S INSURANCE PROGRAM PROPOSED

During a February 5 joint session of the state Senate and House of Representatives, Governor Robert Casey proposed the creation of a comprehensive health insurance program for children up to age 6. Coverage would include preventive care and immunizations, normal doctor visits, in-patient hospitalization, prescription drugs, and dental and vision coverage.

Private, non-profit insurance companies would administer the program, to be overseen by the state Insurance Dpartment. Funding would come from recently imposed taxes on cigarettes, as well as from premiums imposed on families according to a sliding fee scale.

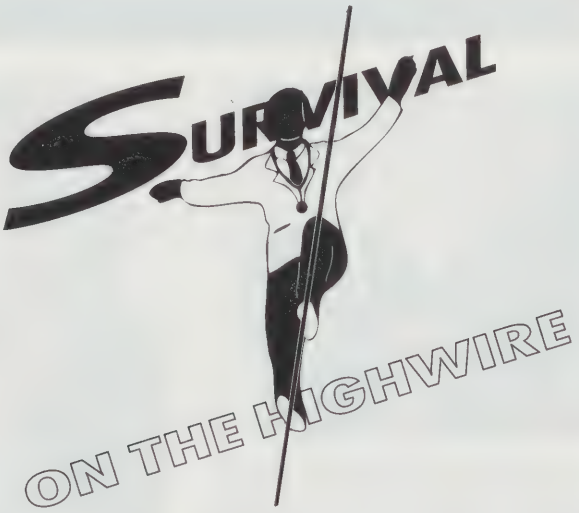
FIRST PHASE OF ADA IN EFFECT

The first phase of the Americans with Disabilities Act (ADA) went into effect in January 1992. This phase of the act, which was written into law in July 1990, requires that places open to the public provide access to facilities for disabled individuals, including people in wheelchairs and on crutches, as well as those with hearing, visual, and mental impairments. It also sets forth guidelines for public transit and vehicle accessibility.

For medical practices, the ADA requires physicians to offer disabled patients access to facilities and services equal to that of non-disabled patients. Later phases will mandate employment provisions, including non-discrimination of the disabled in hiring and accomodation of disabled workers.

For detailed information about ADA accessibility provisions, see "The Disabilities Act: How to Comply" in the December 1991 issue of PENNSYLVANIA MEDICINE; more specific information about employment provisions will be included in a future issue of the magazine. Direct any questions to: Susan M. Weber, Esq., State Society assistant general counsel, 1-800-228-7823.

Quality, cost, access — a delicate balance.



Pennsylvania Medical Society

Leadership Conference

April 14-15, 1992
Hershey Lodge and Convention Center, Hershey

- **Eleanor Clift**, *Newsweek* correspondent, and **Fred Barnes**, *The New Republic* writer, will present a point-counterpoint discussion on "Health Care: Election '92."
- **Robert W. McAfee, MD**, vice chairman of the AMA Board of Trustees, will speak on "Practice Parameters."
- **Alice Gosfield, Esq.**, health care law specialist from Philadelphia, will moderate "Can Quality Medicine Survive in a Managed Care Environment?" Panelists will include:
  - **Neil Schlackman, MD**, medical director, U.S. Healthcare, Blue Bell;
  - **Michael A. Hatwick, MD**, practicing physician, Annandale, Virginia; and
  - **David B. Nash, MD**, director of health policy and clinical outcomes at Thomas Jefferson University Hospital and Jefferson Medical College, Philadelphia.
- **Lucian Leape, MD**, lecturer at the Harvard School of Public Health and Tufts University School of Medicine, will speak on "Liability Reform."
- **Feature Workshop**

  Diversity: A Workshop for the Future Leaders of Medicine

  A panel of two young physicians and two experienced leaders of organized medicine will discuss the barriers facing specially challenged physician groups, such as women, blacks, and IMGs.
- **Other workshop topics will include:**
  - Practical Political Involvement for Physicians
  - Coping with KePRO
  - Stress Management
  - Presentation Skills and Image Building
  - The Future of Health Care


Fred Barnes


Eleanor Clift


Alice Gosfield, Esq.

For more information, call 1-800-228-7823 — ask for Leadership Conference Registration.

Deadline for Registration: March 20, 1992

The Pennsylvania Medical Society is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians.

The Pennsylvania Medical Society designates this continuing medical education activity for 7.5 credit hours in Category 1 of the Physicians Recognition Award of the American Medical Association and the Pennsylvania Medical Society membership requirement.



Martin A. Murcek, MD (l), State Society vice president, received a special plaque from the Society's Interspecialty Section in recognition of his years of service and dedication to interspecialty activities. Thomas H. Malin, MD (r), section chairman, in presenting the plaque said, "Dr. Murcek, in his role as the Society's first Interspecialty Trustee, displayed exemplary leadership...and extraordinarily represented his interspecialty constituents."

Milton J. Klein, DO, vice president of Western Pennsylvania Rehabilitation Association of Sewickley, was awarded membership in the American College of Physician Executives.

A. Julio Martinez, MD, professor of neuropathology at the University of Pittsburgh School of Medicine, was chosen by the magazine, *Hispanic Business*, as one of the 100 most influential Hispanic-Americans in the United States.

Jay B. Fisher, MD, general vascular surgeon and co-director of the Non-Invasive Vascular Laboratory at Easton Hospital, was appointed director of the hospital's Surgical Residency Program.

William M. Swartz, MD, and **Joseph C. Banis, MD,** authored the recently published book, *Head and Neck Microsurgery*.

Pittsburgh neurologist **Neil A. Busis, MD,** was named chairman of the Professional Practice Committee of the American Association of Electrodiagnostic Medicine (AAEM) and liaison from the AAEM to the AMA's CPT Advisory Panel.

Donald O. Castell, MD, was appointed Kimbel Professor and chairman of the Department of Medicine at The Graduate Hospital.

Gloria Watkins, MD, a pathologist at Frick Community Health Center, was named president of the Westmoreland County Medical Society.

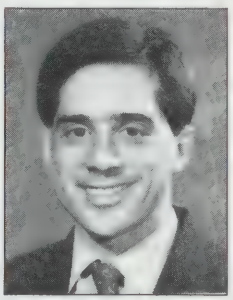
Stuart Heydt, MD, was named president and chief executive officer of the Geisinger Foundation, parent company of the Geisinger health care system. Dr. Heydt most recently served as president of Geisinger Medical Center.

H. Robert Davis, MD, a family practitioner from Boiling Springs, was honored with a proclamation from the state House of Representatives for his distinguished service to fellow citizens. Representative Jerry L. Nailor (R—Monroe) presented the proclamation to Dr. Davis.

Robert B. Greer III, MD, associate dean for medical education and professor and chief of orthopedic surgery at Penn State's Milton S. Hershey Medical Center, retired on December 31, 1991.

Eugene N. Myers, MD, FACS, professor and chairman of the Department of Otolaryngology at the University of Pittsburgh School of Medicine, was recently elected honorary president of the Israeli Section of Head and Neck Surgery and Oncology.

David J. Shulkin, MD, was appointed director of clinical outcomes assessment and quality management at the Hospital of the University of Pennsylvania.



Dr. Shulkin

David P. Connolly, MD, president of the medical staff and director of surgical education at St. Margaret Memorial Hospital, was named president-elect of the Pittsburgh Surgical Society.

Barry L. Reimer, MD, director of orthopedic trauma at Allegheny General Hospital, has been named to the editorial board of *Orthopedics*.

Robert M. Hamaty, MD, a member of the Department of Obstetrics and Gynecology at Lee Hospital, Johnstown, was elected president of Lee's medical staff.

David C. Martin, MD, was appointed chief of geriatric medicine at West Penn Hospital.

L. Matthew Schwartz, MD, physiatrist at the Center for Rehabilitation Sciences at the Philadelphia College of Osteopathic Medicine, has joined the Department of Physical Medicine and Rehabilitation at Osteopathic Medical Center—City Avenue Campus.

Henry D. Berkowitz, MD, associate professor of surgery at the University of Pennsylvania School of Medicine and university associate at Children's Hospital in Philadelphia, was appointed chief of the Division of Vascular Surgery at Presbyterian Medical Center.



Dr. Berkowitz

Daniel A. Deutschman, MD, was named medical director of the Center for Psychiatric Medicine at St. Francis Medical Center.

Barry B. Goldberg, MD, director of the Division of Diagnostic Ultrasound and professor of radiology at Thomas Jefferson University, was named president-elect of the World Federation for Ultrasound in Medicine and Biology.

Freddie Fu, MD, vice chairman of the Department of Orthopedic Surgery and medical director of the Sports Medicine Institute at the University of Pittsburgh Medical Center, was honored by the Pennsylvania State Association for Health, Physical Education, Recreation, and Dance for his outstanding service and contributions.

Joseph C. Flanagan, MD, a plastic surgeon at Lankenau Medical Center, spoke at three Wills Eye Hospital

CORRECTION

On the Newsmakers page of the January 1992 issue of PENNSYLVANIA MEDICINE, Bernard J. Ostrum, MD, is incorrectly identified as a radiologist at Nazareth Hospital. Dr. Ostrum is a radiologist at Albert Einstein Medical College. His father, Herman W. Ostrum, MD, is employed by Nazareth Hospital.

programs on the subjects of orbital fractures, eyelid reconstruction, and entropion/ectropion.

Marvin E. Steinberg, MD, director of the Joint Reconstruction Center at the Hospital of the University of Pennsylvania and professor of orthopedic surgery at the University of Pennsylvania Medical School, presented four papers and a poster at the 59th annual meeting of the American Academy of Orthopedic Surgeons in February in Washington, DC.

A. Michael Pirone, MD, orthopedic surgeon, and **Thomas E. Hargest Jr., MD, PhD,** family practitioner, have joined the medical/dental staff of Andrew Kaul Memorial Hospital, St. Marys.

Harvey W. Scholl Jr., MD, was appointed chairman of the Department of Radiology at Grand View Hospital, Sellersville. Also, **Rijni B. Patel, MD,** pediatrician, and **Yung Sup Kim, MD,** internal medicine specialist, were named to Grand View's medical staff.

Reed Haag, MD, of Waverly, has joined Guthrie Clinic and Robert Packer Hospital as an associate in internal medicine.



Robert B. Edmiston, MD, senior vice president of professional affairs for Pennsylvania Blue Shield, and Bonnie Tabor, managed care specialist, presented a special "Key Issues Forum" on BlueChoice at the December meeting of the Allegheny County Medical Society's Board of Directors.

Louis Catalano, MD, and **Carolos J. Marerro, MD,** have joined the consulting medical staff at Frick Community Health Center, Mount Pleasant, with privileges in neurology.

Robert G. Bowman, MD, medical director of the mental health units at Highlands Hospital and Highlands Health Center, has become certified by the American Board of Psychiatry and Neurology in the subspecialty of geriatric psychiatry.

Eugene Y. Kim, MD, radiology specialist, has joined the medical staff at Brownsville Medical Hospital.

John L. Turner, MD, an endocrinologist at The Graduate Hospital, was honored by the assistant secretary of health for his outstanding volunteer efforts in the care and treatment of people with AIDS.

Raymond E. Adams, MD, director of cataract and primary care service at Wills Eye Hospital, has been elected president of the Section of Ophthalmology of the College of Physicians of Philadelphia.

GEISINGER CLINIC

1992 Continuing Education Programs

Contemporary Issues in Internal Medicine
Wednesday, March 11, 1992

Advanced Trauma Life Support Provider Course (ATLS)
Friday & Saturday, March 13 & 14, 1992

Advances in Dermatology
Wednesday, April 1, 1992

Advanced Cardiac Life Support Renewal Course
Saturday, April 4, 1992

Update in Family Practice
Wednesday, April 8, 1992
Danville Days Inn

2nd Annual Focus on Sports Medicine
Saturday, April 11, 1992
Danville Days Inn

Controversies in the Management of Prostate Diseases
Wednesday, April 15, 1992

Pediatric Advanced Life Support Provider Course
Thursday, Friday, April 23 & 24, 1992

Airway Diseases
Wednesday, April 29, 1992

6th Annual Sight Loss Support Group Meeting
Wednesday, May 6, 1992
Danville Days Inn

Care of the Diabetic with the Dysvascular Foot
Wednesday, May 13, 1992

Update in Obstetrics & Gynecology
Wednesday, May 20, 1992
Danville Days Inn

6th Annual Symposium in Clinical Medicine
June 22-25, 1992
Hilton Head Island, SC

Please check each specific flyer as it arrives for starting time, location, number of credit hours, and types of credit. Programs may be cancelled due to insufficient registration. If not pre-registered, please call to confirm the program.

Geisinger

As an organization accredited by the Pennsylvania Medical Society for its continuing medical education program, the Geisinger Clinic designates these activities as meeting the criteria for Category I credit for the American Medical Association's Physician's Recognition Award and the Pennsylvania Medical Society membership requirement. Please refer to each individual program flyer for registration fees, starting times, and number of credit hours. For further information or for copies of individual programs, call Sharon Hanley, RMP, collect, at 717-271-6692. There is a 24-hour answering service available. You may also write to her at North Academy Avenue, Danville, PA 17822-1350.

LEADERSHIP CONFERENCE TO INCLUDE DIVERSITY WORKSHOP

"Diversity: A Workshop for the Future Leaders of Medicine" has been added to the agenda of the State Society's 1992 Leadership Conference, "Survival on the High Wire." The conference is scheduled for April 14-15, 1992, at the Hershey Lodge and Convention Center. Registrations are due no later than March 20.

The "diversity" workshop, sponsored by the Leadership Institute of the Society's Educational and Scientific Trust, will feature a panel of two young physicians and two experienced leaders of organized medicine to candidly discuss the barriers facing three specially challenged physician groups: women, blacks, and international medical graduates. While the young physicians will describe the obstacles they are facing, the physician leaders will offer their experiences and advice on how they broke through the barriers to attain the positions they now hold.

Leading this year's "Stress Management" workshop is Robert S. Eliot, MD, FACC, director of the Institute of Stress Medicine International in Denver, Colorado. Dr. Eliot is a professor of cardiology, has authored several publications and serves as a medical consultant for several major national corporations and foreign governments.



Dr. Eliot

In 1989, he was awarded the Science and Art of Health Award by the Rockefeller Foundation's Institute for the Advancement of Health in New York City. The previous year's recipient was Dr. Jonas Salk. Dr. Eliot's interest in stress and its effect on health derives from more than two decades of study, research, and care of patients around the world.

Recognizing a need for physicians to become more involved in politics at a grassroots level, the State Society has designed a workshop on "Practical Political Involvement for Physicians." Experts will present practical information to physicians to help them speak effectively with legislators about medical issues. Tentative speakers include members of AMPAC, the American Medical Political Action Committee, as well as legislative staff members from Harrisburg and/or Washington.



Alice Gosfield, Esq., of Philadelphia, will moderate a panel discussion entitled, "Can Quality Medicine Survive in a Managed Care Environment?" during the Society's 1992 Leadership Conference.

Several other practical topics will also be addressed. Robert E. McAfee, MD, vice chairman of the AMA Board of Trustees, will keynote the conference with a presentation on practice parameters. Eleanor Clift, *Newsweek* correspondent, and Fred Barnes, *The New Republic* writer, will offer a political point-counterpoint discussion, "Health Care: Election '92."

The conference registration fee is $60 for Society members and $80 for non-members. This includes workshops, handout materials, Tuesday reception and dinner, Wednesday breakfast, and refreshment breaks both days. Attendees may receive 7.5 hours of Category 1 continuing medical education (CME) credit. For registration materials and information, call 1-800-228-7823.

MEMBERSHIP NUMBERS REACH RECORD HIGH

Recruitment efforts of the Pennsylvania Medical Society have proven successful in reaching a record-high total for membership. Figures from 1991 show total Society membership at 21,111, a 2.9 percent increase from the 1990 figure of 20,513. The breakdown of new members in 1991 is: 323 full active, 90 residents, 200 students, 12 military, 10 disability, 34 associates, and 28 affiliates.

The Council on Membership is relying on its 1992 Recruitment Plan to increase membership even further and strengthen the Society's position on a national level. The plan focuses on recruitment on a county level and through direct-mail efforts. At the direction of the Society's Board of Trustees, the Council on Membership is also investigating the feasibilty of offering group membership rates in the future.

STATE SOCIETY LEADERS VYING FOR AMA OFFICES

As a unified state with the AMA, Pennsylvania is concerned with increasing member involvement and strength on the national level of organized medicine. The State Society's Board of Trustees is endorsing several candidates for AMA positions: Robert N. Moyers, MD, State Society president, for a position on the Council on Medical Education; Lee H. McCormick, MD, for chairman of the AMA Hospital Medical Staff Section; Ronald J. Clearfield, MD, for a position on the Council of Constitution and Bylaws; and John J. Whyte for student trustee.

DOCTORS' DAY SET

The Pennsylvania Medical Society has set aside March 30 as "Doctors' Day" to recognize physicians for their dedication, leadership, and contributions to the Society. Doctors' Day was first celebrated in 1933 in Georgia, and today is recognized nationally. In Pennsylvania, county medical society auxiliaries are planning a variety of events in honor of physicians.

TRUST LOANS UP 2.1 PERCENT FROM 1990

In 1991 The Educational and Scientific Trust of the Pennsylvania Medical Society provided to needy students $479,828 in regular loans, up 2.1 percent from the $469,850 provided in 1990. Of the 1991 total, medical students and children of deceased or disabled physicians received $425,500, and allied health students received $54,328.

Last year, for the first time, the

Trust also offered Residency Relocation Loans, which were developed to provide medical school graduates with a less expensive loan alternative to cover moving and related expenses. The program—open to all fourth-year students who will receive MD or DO degrees in spring and who have received a Trust loan sometime during their medical education—offers individual loans up to $1,000. In 1991 the Trust loaned a total of $29,000 to graduating medical students through this new program.

Since 1948 when the first loan program was instituted by the State Society, 3,248 individuals received loans totaling in excess of $9 million. The program was moved under the Society's Trust in 1964. Today, applications are considered on a yearly basis. The Society's Trust will begin accepting applications for the 1992-93 school year on April 1. For additional information about available programs, or to receive application materials, call the Trust at 1-800-228-7823.

REFERRAL NETWORK INTRODUCED IN PITTSBURGH

Prologue, a national health care information source, was introduced in the Pittsburgh area in mid-January. The network, designed to provide consumers with information to make an informed choice when selecting a physician, is a database system that matches consumers with physicians by medical needs and personal health care preferences. It was first introduced in 1983; currently serves 10 major U.S. markets, including Pittsburgh and Philadelphia; and networks 8,500 physicians.

PITT ANNOUNCES PharmD PROGRAM

The University of Pittsburgh School of Pharmacy announced in January a new doctoral program, awarding a two-year Doctor of Pharmacy (PharmD) degree. The PharmD is a post-graduate degree students may pursue after completing a five-year undergraduate pharmacy degree.

The program will consist of two parts: 1) advanced course work in the classroom, and 2) experiential services in areas such as transplantation or cardiology as part of a health care team. The new doctoral program will begin this fall with the admission of six students.

PHYSICIANS TOP JOB RESPECT LIST

Physicians/surgeons are most respected in the workplace, according to a survey conducted by the National Opinion Research Center at the University of Chicago. In the survey, 1,166 adults nationwide rated the status of 740 occupational titles.

"The top ranking doesn't surprise me," said James S. Todd, executive vice president of the American Medical Association. "When people stop and think about this profession, they realize that the work of physicians in general is beneficial." He added that as a physician, "you really influence the course of disease; you're actually there doing something that makes a difference."

The survey was conducted "to measure social consistency and social change and to develop models to explain why society has changed and why it has not," according to survey director Tom W. Smith. The survey was first conducted in 1964. At that time, physicians were rated second to college presidents.

SEMINARS TO ADDRESS PUBLIC HEALTH POLICY

The Leonard Davis Institute (LDI) of Health Economics at the University of Pennsylvania has scheduled the following seminars as part of the series, "The Role of the Private Sector in Setting Public Health Care Policy":

March 19, 1992
Turning up the Volume: A Journalist's Perspective on Health Care Reform
Ron Winslow, Health Care Report, *Wall Street Journal*

April 2, 1992
National Health Reform: The UAW Perspective
William S. Hoffman, PhD, Director of Social Security, United Auto Workers

April 9, 1992
Lobbying is Not a Dirty Word: Professional Societies, Health Reform, and the Public Interest
John R. Ball, MD, JD, Executive Vice President, American College of Physicians

All seminars will be held in the Colonial Penn Center Auditorium, 3641 Locust Walk, Philadelphia, from 4:30-6:00 p.m. For additional information, call (215) 573-3043.

NEW PATHOLOGY JOURNAL PUBLISHED

The first issue of *Cardiovascular Pathology* was published by Elsevier Science Publishing Company, Inc.,as the official journal of the Society for Cardiovascular Pathology. Stephen M. Factor, MD, of the Albert Einstein College of Medicine in Bronx, New York, will serve as editor of the international journal.

The primary object of *Cardiovascular Pathology* is to publish articles on disease-oriented morphology and pathobiology from pathologists and non-pathologist investigators in the cardiovascular field. The journal will also publish reviews and case reports.

CENTRAL PA EMPLOYERS FAVOR NATIONAL HEALTH INSURANCE

With health care reform increasingly in the national political spotlight, Central Pennsylvania employers say they favor some form of national health insurance, according to the findings of a random survey, sponsored by HealthAmerica Central Pennsylvania, of benefits managers at 100 Central Pennsylvania companies.

Sixty-four percent of respondents favor government-established national health insurance that would cover everyone in the country. Thirty percent opposed the idea, and six percent weren't sure. Those results closely parallel Pennsylvania's Senate race, in which Senator Harris Wofford received 66 percent of the vote after making national health insurance the central issue in his campaign. Despite the support voiced for national health insurance, many respondents expressed doubt that such a program would either save money or improve the quality of care.

In other findings, 73 percent of respondents agree that the right of patients to sue physicians and hospitals should be limited by law, and 52 percent agree that the government should require all businesses to provide some form of health insurance to their employees. Asked to identify where "a great deal" of the blame should go for rising medical costs, the respondents listed physicians third, below malpractice lawsuits and lawyers.

QUARTERLY REPORTS FROM KEPRO OVERSEERS

The House of Delegates, through Resolution 86-44 (Amended), has mandated the Society to provide regular reports on Keystone Peer Review Organization (KePRO) findings. The following report from the Ad Hoc Committee on KePRO Oversight covers the period October 1 through December 31, 1991. It shows the number of Medicare discharges, cases reviewed by KePRO physician reviewers, pending denials issued, final denials issued, and DRG changes made by KePRO.

KePRO Data for All Pennsylvania Hospitals 10/01/91 - 12/31/91

Medicare Discharges	*180,411
Cases Reviewed	36,723
Admission Denials	550
Administrative Denials	265
Total Denials	815
DRG Changes	949
PPS Hospitals Under IR	**4
Generic Screen Failures	28,874
Pending Quality Problems	4,884
Confirmed Quality Problems	340

* Reflects total discharges received by KePRO for the reporting quarter.

**Reflects total PPS hospitals proposed to begin IR as a result of initial analysis of fourth-quarter review results.

SOCIETY COUNCILS DISCUSS 1992 PRIORITIES

Five councils serve the State Society in the areas of education and science, government relations, medical economics, medical practice, and membership. Each council monitors specific issues affecting the medical community, reports and makes recommendations to the Board of Trustees about its activities, and prepares an annual report for the House of Delegates. Council members are appointed annually by the incoming Society president, subject to the approval of the Board.

In early February, council chairmen met with the Board's Executive Committee to discuss priorities for 1992. The following is a list of chairmen, priorities, and staff contacts for each council:

Council on Education and Science

Chairman: Gilbert A. Friday Jr., MD

Priorities:

- Construct a public health plan to address national disease prevention and health promotion
- Push for legislation on issues related to maternal and child health
- Monitor the status of establishing toxic waste incineration sites in Pennsylvania and develop a position statement for the Society
- Continue involvement in addressing AIDS-related issues
- Monitor prioritization of care issues

Staff Contact: Jeffrey C. Greenawalt

Council on Governmental Relations

Chairman: Andre C. Blanzaco, MD

Priorities:

- Promote the Society's legislative priorities: workers' compensation reform, care for the medically uninsured and underinsured, and medical liability tort reform
- Coordinate a grassroots lobbying effort to promote Society positions on issues
- Seek legislative action to amend the AIDS Confidentiality of HIV-Related Information Act (Act 148 of 1990)
- Seek increases in the Medicaid outpatient line of the state's general fund budget
- Monitor state and federal regulations, and coordinate an organized response mechanism for use by various sectors of the Society

Staff Contact: Jerry L. Rothenberger

Council on Medical Economics

Chairman: John J. McAndrew, MD

Priorities:

- Develop and monitor Society activities related to Medicare payment reform and the RBRVS payment system
- Work with the Department of Public Welfare to develop educational and training programs for physicians, and to improve communication between the Department and providers
- Continue to monitor and respond to changes in reimbursement policies of third-party insurers
- Develop and implement a Society ombudsman program to address problems associated with third-party payor reimbursement

Staff Contact: Dennis L. Olmstead

Council on Medical Practice

Chairman: Michael J. Prendergast, MD

Priorities:

- Develop products and services designed to meet member needs
- Manage endorsed insurance and seminar programs
- Produce and distribute publications focusing on RBRVS and other reimbursement issues
- Publish comprehensive manuals on laws and regulations affecting medical practice, and guidelines for physicians to purchase insurance
- Establish a legal service plan for physicians involved in disputes with third parties
- Expand the Medical Staff Legal Service Plan pilot program into a statewide program
- Study the feasibility of establishing a medical records storage and retrieval service for physicians

Staff Contact: Sharon R. Orlowski

Council on Membership

Chairman: O. Fred Miller III, MD

Priorities:

- Increase principal dues-paying physician members by 400
- Increase resident physician members by 350 and student members by 160
- Target selected segments—medical groups, women physicians, and international medical graduates—for recruitment
- Implement peer-to-peer recruitment activity through county medical societies and the Hospital Medical Staff Section (HMSS)
- Develop and implement improved retention activities at the state and county levels

Staff Contact: L. Reigel Haas



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AIR FORCE

OBITUARIES

Matthew A. Aini, DO, *Fairview*
Kirksville College of Osteopathic Medicine, 1961; age 59, died December 14, 1991. Dr. Aini was a general practitioner.•

Raymond G. Blood, Jr., MD, *Philadelphia*
Hahnemann University, 1944; age 72, died December 21, 1991. Dr. Blood was a general practitioner.•

Louis S. Bringhurst, *Kennett Square*
University of Pennsylvania School of Medicine, 1935; age 84, died November 15, 1991. Dr. Bringhurst was a radiologist.•

William W. Christman, MD, *Selinsgrove*
Hahnemann University, 1946; age 71, died December 12, 1991. Dr. Christman was a clinical pathologist.•

John J. Curtin, MD, *Rosemont*
Hahnemann University, 1934; age 83, died January 6, 1992. Dr. Curtin was an internist.•

Russell W. Hill Jr., *West Chester*
University of Pennsylvania School of Medicine, 1952; age 71, died November 17, 1991. Dr. Hill specialized in emergency Medicine.•

W. Kahle Johnson, MD, *New Kensington*
University of Pittsburgh, 1955; age 63, died January 13, 1992. Dr. Johnson was an internist.•

Marvel S. Kirk, MD, *Lancaster*
Medical College of Pennsylvania, 1929; age 85, died December 28, 1991. Dr. Kirk was an obstetrician.•

Ira B. Kron, MD, *Altoona*
New York University, 1958; age 58, died January 20, 1992. Dr. Kron was an internist.•

Frederic C. Lechner Jr., *Williamsport*
Jefferson Medical College, 1946; age 68, died November 11, 1991. Dr. Lechner was an internist.•

David Levenberg, MD, *Jenkintown*
Hahnemann University, 1967; age 51, died December 17, 1991. Dr. Levenberg was a psychiatrist.•

Arthor E. Martin, *Lititz*
University of Rochester School of Medicine and Dentistry, 1935; age 84, died November 26, 1991. Dr. Martin was an internist.•

Robert C. Mitterling, *Elizabethtown*
University of Pennsylvania School of Medicine, 1939; age 78, died November 27, 1991. Dr. Mitterling specialized in cardiovascular diseases.•

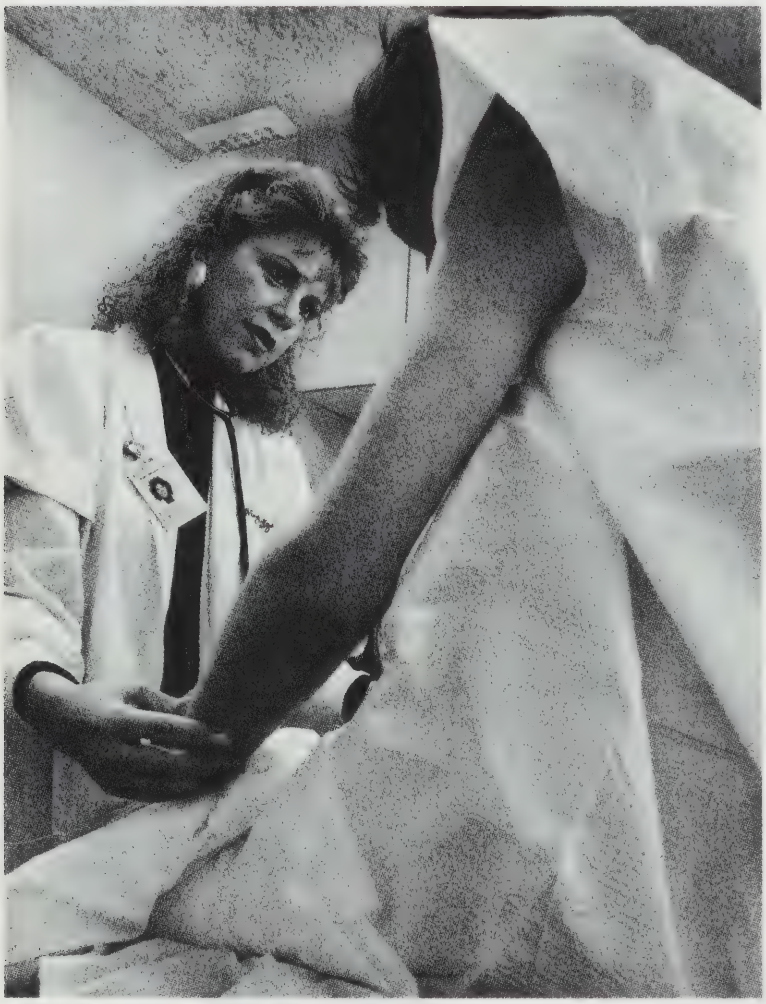
Edward J. Murphy, *Bryn Mawr*
Jefferson Medical College, 1944; age 72, died November 28, 1991. Dr. Murphy was a gynecologist.•

Hugo B. Paul, *New Canaan, CT*
University of Pittsburgh School of Medicine, 1926; age 90, died October 29, 1991. Dr. Paul was a psychiatrist.•

James A. Rosen, *Greensburg*
University of Pittsburgh School of Medicine, 1955; age 61, died November 23, 1991. Dr. Rosen was a neurologist.•

George R. Shore, MD, *Pittsburgh*
Temple University, 1946; age 69, died January 2, 1992. Dr. Shore specialized in occupational medicine.•

Murray K. Spillman, MD, *Lancaster*
Temple University, 1932; age 89, died December 22,1991. Dr. Spillman was a general practitioner.•



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Dr. Aliza Lifshitz, Internist, Los Angeles, California,
Member, American Medical Association

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Frank V. Thompson, MD, *Nazareth*
University of Pennsylvania, 1936; age 79, died December 17, 1991. Dr. Thompson was a general practitioner.•

Joseph Calafiore, *Johnstown*
College of Osteopathic Medicine; age 93, died November 28, 1991.

Thomas H. Cannard, *Havertown*
University of Pennsylvania School of Medicine, 1951; age 70, died November 5, 1991. Dr. Cannard was an anesthesiologist.

F. Curtis Dohan, *Bala Cynwyd*
University of Pennsylvania School of Medicine, 1932; age 84, died November 9, 1991. Dr. Dohan was an internist.

Robert J. Gallagher, *Yeadon*
Hahnemann University School of Medicine, 1939; age 77, died November 11, 1991. Dr. Gallagher was a general practitioner.

Vijay K. Gohel, MD, *Cherry Hill, NJ*
University of Bombay, 1956; age 59, died December 5, 1991. Dr. Gohel was a radiologist.

John W. Keyes, *Jermyn*
Jefferson Medical College, 1942; age 86, died November 1, 1991. Dr. Keyes was a general practitioner.

Robert Maglieri, DO, *Hereford*
Philadelphia College of Osteopathic Medicine; age 67, died December 5, 1991.

Lewis C. Mills Jr., *Mt. Laurel, NJ*
Baylor College of Medicine, 1946; age 68, died November 27, 1991. Dr. Mills was an endocrinologist.

Stewart L. Rankin, MD, *Springfield*
Jefferson Medical College, 1930; age 86, died December 7, 1991.

Douglass S. Thompson, MD, *Pittsburgh*
Boston University, 1951; age 68, died December 6, 1991. Dr. Thompson was an obstetrician.

Walter Uzych, MD, *Wallingford*
University Hospital in Graz, Austria, 1940; age 77, died December 25, 1991. Dr. Uzych was an otolaryngologist.

Robert J. White, *Turbotville*
University of Chicago Pritzker School of Medicine, 1963; age 53, died November 14, 1991.

•Denotes membership in the Pennsylvania Medical Society at time of death.

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1991 Annual Report

To Our Friends:

1991 has been a year of tremendous growth for The Educational and Scientific Trust. In the past year, we have moved steadily toward accomplishing our simply stated purpose, "Research to build the future; Education to protect it."

During 1991, the Trust awarded nearly $500,000 in student loans, renewed its commitment to addressing public health issues, and offered seminars through The Institute for Physician Leadership. In its third year of operation under the Trust, the Physicians' Health Programs (PHP) continued to aggressively pursue its mission of addressing the problems surrounding physician impairment.

In June 1991, the Trustees and staff held a planning retreat to determine what programs will best serve the needs of the public and the medical profession. We identified the following future challenges for the Trust.

- *Recognizing and addressing emerging public health needs.*
- *Equipping physicians to adopt a leadership role in responding to current and future health concerns through The Institute for Physician Leadership.*
- *Expanding PHP services to hospitals including development of model policies for hospital impairment programs.*
- *Supporting the Pennsylvania Medical Society's priorities through projects, research, and loan programs.*

As Chairman of the Board of Trustees, I am proud to share with you the Trust's most notable achievements during 1991. And I can promise you that we will continue to affirm our commitment to Pennsylvania's physicians, and above all, to the public we serve. I look forward to and thank you for your continued support of the Trust in 1992.

Sincerely,

Abram M. Hostetter, MD
Chairman, Board of Trustees

THE EDUCATIONAL & SCIENTIFIC TRUST
of the Pennsylvania Medical Society
777 East Park Drive
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Loan Programs

During the 1990-91 school year, the Trust continued to support Pennsylvania residents pursuing health careers. We provided 157 medical students and 40 allied health students with low-interest loans totalling $479,828.

In 1991, the Trust introduced the Residency Relocation Loan. This new loan provides financial support for Trust borrowers entering residency training programs. Recipients can receive up to $1,000 to help with relocation and living expenses. Twenty-nine students took advantage of this loan in 1991.

To help the Pennsylvania Medical Society give members the option of paying their dues in installments, we again offered an installment dues loan. The Trust paid the annual unified dues for 16 Society members and they repaid the Trust in quarterly payments.

The Trust continues to enhance its relationship with future physicians. In 1991, we again offered to pay our loan beneficiaries' student membership dues in the Pennsylvania Medical Society. We also initiated a new way to interact with medical student borrowers - medical student luncheons. The Trust visited six of Pennsylvania's eight medical schools and invited borrowers to a special "Get to Know the Trust" luncheon. Representatives from the Trust's loan department distributed information and answered questions about student loans. The attendees also had a chance to thank those who help make their loans possible by signing thank-you cards that were then mailed to Trust contributors.

For the 18th consecutive year, the Trust sponsored a one-day workshop for the financial aid officers of Pennsylvania's medical schools. The meeting provides a much-needed forum for financial aid personnel and government loan officials to exchange information. At this year's workshop, the Pennsylvania Medical Society Auxiliary presented more than $99,000 in American Medical Association Education and Research Foundation (AMA-ERF) funds to the state's eight medical schools.

Physicians' Health Programs

The Physicians' Health Programs underwent many changes during 1991. Under the leadership of a new medical director, Penelope Ziegler, MD, the PHP began to develop stronger cooperative relationships with hospitals and treatment centers across the state. Dr. Ziegler and staff members visited hospitals and county medical societies to discuss impairment issues and explain the PHP's services.

In 1991, the number of physicians enrolled in the program grew. The majority of the 307 active program participants are male physicians suffering from drug, alcohol, or a combination of drug and alcohol dependence. However, a sizable percentage present neuropsychiatric illnesses, physical disabilities, and problems related to aging. To help handle its increasing case load, the PHP hired two additional case managers in 1991. Both are registered nurses who have extensive experience in the impairment field.

In 1989, the PHP initiated a program to address an important need of program participants. Physicians enrolled in the PHP and ready to re-enter medicine can apply to receive up to $1,000 a month for living expenses through the Trust's Re-entry of Practice Loan. Over $45,000 was loaned to five recovering physicians in 1991.

Special Projects and Management Support

In addition to conducting numerous projects in 1991, the Trust provided various research and management services to health-related organizations. Continuing in its tradition of using a marketing approach to conduct studies, the Trust completed the following projects during the past year.

- **Aging Resource Directory** - This comprehensive directory of resources for senior citizens was completed for the Pennsylvania Medical Society's Task Force on Aging.
- **AIDS: Information for Physicians Update** - The Trust updated the original AIDS booklet prepared for the Society in 1988.
- **Auto Insurance Reform Research** - The Trust provided assistance to the Society's Legal Department in identifying the ramifications of the state's new automobile insurance law on rural practitioners.
- **Diabetes Product Testing** - The Trust test-marketed prototypes of professional educational materials for the Pennsylvania Diabetes Academy.
- **Drug Decriminalization** - At the request of the Society's Task Force on Drug Abuse, the Trust prepared a white paper on the decriminalization of drugs.
- **Elder Abuse Training and Public Awareness Campaign** - The Trust and the Pennsylvania Department of Aging co-sponsored a campaign to increase awareness of elder abuse among professionals and the public.
- **Family Practice Study** - The Trust conducted this study for the Society's Task Force on the Medically Underserved to determine why medical students choose or do not choose to specialize in family practice.

• **KePRO Medicare Rights Video** - The Pew Foundation awarded the Trust a grant to produce a video on the rights of older Pennsylvanians under Medicare review. This was a joint effort with the Keystone Peer Review Organization (KePRO).

• **Leadership Conference** - The Trust assisted the Society in obtaining speakers and planning its annual Leadership Conference.

• **Medicaid Participation Survey** - For the Society, the Trust coordinated the surveying of physicians specializing in family practice and obstetrics/gynecology to determine participation levels in the state's Medicaid program.

• **Medical School Faculty Study** - This study identified the perceptions medical school faculty have of organized medicine and recommended how the Society could address this group's unique needs.

• **Medicare Pilot Study** - The Trust conducted this study for the Society's Task Force on the Medically Underserved to determine the effects of the state's balance billing legislation on physicians' practices.

• **MedisGroups Study** - The Trust helped develop a written survey conducted with the Hospital Association of Pennsylvania. The survey was designed to evaluate the hospital community's feelings on the MedisGroups system and the Pennsylvania Health Care Cost Containment Council. The Trust conducted a follow-up telephone survey to gain more detailed information from survey respondents.

• **Membership/Leadership Poll** - The Trust surveyed Society members and leaders to determine their views on critical health-related issues. The results were then compared to a Gallup public opinion poll.

• **Pennsylvania Public Health Association Membership Study** - The results of this membership survey led to recommendations for increasing PPHA membership and member satisfaction.

• **Policy Compendium** - At the request of the Society, the Trust developed a data base of Society policies dating back to 1965 and edited the raw data into a published compendium mirroring the appearance of the American Medical Association's.

• **Presidential Remarks** - The Trust prepared remarks for the Society's president on several occasions, including his presentation at the Health Care Forum.

• **Readership Surveys** - The Trust designed studies to measure the effectiveness of the Society's primary communications tools: EXECUTIVE REPORT and PENNSYLVANIA MEDICINE.

• **Trust Newsletter** - The Trust introduced "Connections: News from The Educational and Scientific Trust" in the fall of 1991. This newsletter is designed to keep contributors and other interested parties up-to-date on current Trust activities.

During 1991, the Trustees also reaffirmed the Trust's commitment to addressing public health issues. As a step in this direction, the Trust is publishing and distributing a report entitled, "Healthy Pennsylvania 2000." This report is part of a nationwide initiative to address public health issues. The Trust plans to hold a statewide conference during 1992 to determine public education needs and prepare a grant application outlining a strategy to help public health agencies achieve the report's objectives.

In addition, the Trust continued to help medical specialty societies and related groups run efficient, cost-effective organizations by providing accounting services, marketing and communications consultation, literature searches, editing services, and administrative support. The Trust has 15 organizations as clients for these services. The Trust also began offering assistance with writing, editing, and designing specialty society newsletters in 1991. Four specialty societies used the Trust's newsletter services in 1991.

Medical Legacy Fund

As the support base of the Trust continues to grow, we have added planned giving to our fund-raising program. Planned gifts offer contributors income tax, capital gains tax, and inheritance tax advantages and enable them to include the Trust in their estate plans.

To accept planned gifts, the Trust formed the Medical Legacy Fund in 1991. This fund offers contributors the opportunity to create charitable gift annuities, charitable remainder unitrusts, and charitable remainder annuity trusts. Gifts to the Medical Legacy Fund can be used to support existing programs of the Trust such as student loans or to establish new programs which meet our mission. In either case, contributors create a lasting legacy to medicine.

The Institute for Physician Leadership

In its first full year of operation, The Institute for Physician Leadership proved to be a valuable resource for leaders of the Pennsylvania Medical Society, county and specialty societies, hospital medical staffs, and physician executives. The purpose of the Institute is to better equip physician leaders to: guide organized medicine; deal with the complexities of today's health care environment; and become recognized leaders in community and civic organizations.

During 1991, the Institute:

- Conducted a full-day workshop for the Board of Directors of the Pennsylvania Academy of Family Physicians;
- Introduced leadership theory to the senior staff of the Pennsylvania Medical Society, the Pennsylvania Medical Society Liability Insurance Company, and the Keystone Peer Review Organization;
- Presented a half-day workshop for county and specialty society executives;
- Provided two physician leadership workshops at the Pennsylvania Medical Society's Leadership Conference;
- Presented a workshop on the Myers-Briggs Personality Type Indicator for staff of the Society and its affiliates;
- Presented a half-day workshop for the Society's Hospital Medical Staff Section;
- Presented an introduction to leadership training for the Society's Young Physician's Section; and
- Participated with Jefferson Medical College in a joint application for foundation funding of leadership training for residents.

The Institute has been financed by four partners: Jefferson Medical College, the Pennsylvania Academy of Family Physicians, the Pennsylvania Medical Society, and The Educational and Scientific Trust.

THE INSTITUTE FOR PHYSICIAN LEADERSHIP

Contributors

The Trust is pleased to recognize those individuals and groups whose support made the past year a success. Their contributions demonstrate their commitment to The Educational and Scientific Trust.

The Trust once again thanks the Pfahler Foundation, administered by the Philadelphia County Medical Society, for its 1982 student loans receivable. The Trust has now collected more than $133,000 in principal and interest. Only four loans remain outstanding representing $4,500 in principal. Over the years, these funds have been added to the Medical Student (Educational) Fund to help support new student loans.

The Trustees and staff of the Trust extend their heartfelt thanks to all those who supported the Trust in 1991.

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Memorial and honorary gifts create a lasting remembrance of special individuals while serving others. Making a memorial or honorary contribution is a rewarding way to acknowledge a friend or relative's accomplishments and successes. The following individuals have been memorialized through contributions to the Trust.

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The Trust has made every effort to give proper recognition to all individuals and organizations supporting the Trust in 1991. If we made an error, we apologize. Please contact the Trust so we may correct our records.

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The Trust gratefully acknowledges the individuals, organizations, and hospital medical staffs and administrations who supported the Physicians' Health Programs in 1991. Key Supporters, designated by bold type, are hospitals which made a founding gift of $10 per medical staff member to the PHP.

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***Bold** Indicates Key Supporter*

Balance Sheet at December 31, 1991

	Current		Funds Specified for			1991	1990
	Unrestricted Funds	Restricted Funds	Student Loan Programs	Physicians' Health Programs	Endowment Funds	Total All Funds	Total All Funds
ASSETS:							
Cash	(21,189)	64,037	(108,917)	27,696	7,414	(30,960)	(39,568)
Investments, at lower of cost and market	17,128	177,100	131,197	218,918	52,016	596,358	925,776
Student Loans Receivable	0	3,734	5,391,666	0	0	5,395,400	4,804,816
Other Loans Receivable	0	20,000	0	52,955	0	72,955	22,657
Accounts Receivable	28,526	1,395	9,193	26,061	1,100	66,275	29,025
Office Equipment	41,512	0	0	0	0	41,512	25,682
Prepaid Expenses	5,284	0	0	3,638	0	8,922	2,681
TOTAL ASSETS	***71,261***	***266,266***	***5,423,139***	***329,268***	***60,530***	***6,150,463***	***5,771,069***
LIABILITIES AND FUND BALANCE:							
Accounts Payable	11,780	0	142	3,892	0	15,813	22,865
Accrued Taxes	245	0	0	114	0	360	30
Unearned Revenue	0	0	0	0	0	0	0
Total Liabilities	**12,025**	**0**	**142**	**4,006**	**0**	**16,173**	**22,895**
Fund Balance	**59,236**	**266,266**	**5,422,997**	**325,262**	**60,530**	**6,134,290**	**5,748,174**
TOTAL LIABILITIES AND FUND BALANCE	***71,261***	***266,266***	***5,423,139***	***329,268***	***60,530***	***6,150,463***	***5,771,069***

Schedule of Revenue and Expense for the year ending December 31, 1991

	Current		Funds Specified for			1991	1990
	Unrestricted Funds	Restricted Funds	Student Loan Programs	Physicians' Health Programs	Endowment Funds	Total All Funds	Total All Funds
REVENUE:							
Administrative Grants/Dues Allocations	83,200	0	131,273	225,000	0	**439,473**	**464,207**
Contributions	9,496	13,685	49,536	54,640	6,450	**133,807**	**197,090**
Revenue from Outstanding Loans	371,216	0	0	1,841	0	**373,057**	**220,214**
Investment Revenue	5,005	9,156	8,560	12,754	2,116	**37,592**	**60,496**
Gains on Investments	6,172	13,792	4,900	18,400	3,357	**46,621**	**39,480**
Projects and Programs	97,812	5,975	0	21,194	0	**124,982**	**142,315**
Administrative Services	54,176	0	0	0	0	**54,176**	**51,793**
Miscellaneous	98	0	341	0	0	**439**	**6,341**
Total Revenue	**627,176**	**42,608**	**194,610**	**333,830**	**11,923**	**1,210,147**	**1,181,936**
EXPENSES:							
Salaries and Benefits	449,148	0	0	255,699	0	**704,847**	**567,227**
Travel and Meetings	13,737	3,365	0	18,243	0	**35,345**	**31,533**
Projects and Programs	91,451	10,300	0	16,790	0	**118,541**	**83,065**
Consulting	66,409	2,750	0	30,822	0	**99,981**	**75,153**
Solicitation	18,290	0	0	1,585	0	**19,875**	**32,135**
General and Administrative	93,788	0	0	28,550	0	**122,337**	**119,071**
Miscellaneous	1,992	26	7,927	632	200	**10,778**	**9,839**
Total Expenses	**734,815**	**16,441**	**7,927**	**352,321**	**200**	**1,111,705**	**918,023**
REVENUE OVER/(UNDER) EXPENSES	**(107,640)**	**26,167**	**186,683**	**(18,491)**	**11,723**	**98,442**	**263,913**
FUND BALANCE, beginning of the year	**158,941**	**300,215**	**4,909,291**	**347,561**	**55,160**	**5,771,168**	**5,484,261**
PRIOR PERIOD ADJUSTMENT	**264,680**	**0**	**0**	**0**	**0**	**264,680**	**0**
INTERFUND TRANSFERS	**(256,745)**	**(60,116)**	**327,023**	**(3,808)**	**(6,353)**	**0**	**0**
FUND BALANCE, end of the year	***59,236***	***266,266***	***5,422,997***	***325,262***	***60,530***	***6,134,290***	***5,748,174***

Notes to Financial Statements

Note 1: The financial statements shown in this report are unaudited. Audited statements are currently being prepared and will be available upon request in April.

Note 2 - Funds: Current unrestricted funds are those funds used to maintain the normal operations of the Trust, and do not require prior approval for their use. Current restricted funds are funds held in reserve by the Trust which are not designated for specific purposes, but cannot be used without permission of the Board of Trustees (or others for whom the funds are maintained). Endowment funds are gifts to the Trust to use revenue generated from that gift for a specific purpose.

Note 3 - Investments: Investments in 1991 are recorded at cost - market value is $660,552. In 1990, investments were recorded at market value.

Note 4 - Office Equipment: Office equipment is listed net of accumulated depreciation of $8,392 in 1991, and $13,072 in 1990. Equipment consists largely of computer equipment owned by the Trust.

Note 5 - Revenue from Outstanding Loans: Loan interest is substantially higher in 1991 because of an accounting adjustment which added school and residency interest to a borrower's principal balance. This provides a more accurate description of a borrower's outstanding balance.

Note 6 - Prior Period Adjustments: Some of the addition of school and residency interest had an effect on the student loan interest revenue prior to 1991. Therefore, it is necessary to make an adjustment to the fund balance in prior periods, so the 1991 revenue is not overinflated.

Note 7 - Interfund Transfers: Interfund transfers are transfers of funds within the Trust which have no effect on the revenue and expense of the organization (total balance within all funds is zero). However, these transfers must be noted on the financial statements.

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The New House Officer and the Dying Patient

William M. Cooper, MD, JD

Somewhere along the line in medical education, house officers and even teaching physicians have developed the erroneous idea that they are fighting death. This idea, I think, comes from the dramatization of physicians and their activities in literature, movies, radio programs, and especially in television soap operas. Some physicians entering practice think this is the real world, since such glimpses have been their only view of the practice of medicine.

House officers sometimes become very depressed on services where death is a frequent occurrence (i.e., oncology, hematology, and geriatric services). This is in part because these individuals have not been made aware that their function is to treat a person with illness and not to fight death. Indeed, in my opinion, part of a physician's function is to prepare people for death—not only the patients but their families as well.

"In the teaching of house staff, it is important to delineate between 'fighting death' and treating patients with disease."

In the teaching of house staff, it is important, first of all, to delineate between "fighting death" and treating patients with disease. We cannot fight death indefinitely since, to date, death is an inevitable result of living. If we can get this across to our students, then perhaps they can accept death more graciously and more supportively in those they treat.

Dr. Aring, years ago, in the *Journal of the American Medical Association*, wrote a beautiful article on the difference between sympathy and empathy in the management of patients with terminal disease states. He says that in "empathy," one feels and relates but is able to maintain objective judgment regarding the problems of the patient, whereas in "sympathy"—where one places himself and feels as the patient would feel—objectivity is sometimes lost in the management of the patient. This is an extremely important point, not only for the patient's benefit but also for the benefit of the physician who must handle this sort of problem frequently in his life's practice.

A second point to impress upon anyone in attendance of a terminally ill patient is the effect a change in tone of voice or empathy may have upon the patient. Interviewing a dying patient is much different from caring for the patient day-in and day-out. The slightest change in attitude or activity has a great bearing on that patient's reaction to his or her situation. This creates marked stresses on the physician, as well as the patient, as they watch each other for sign language, body language, and changes in attitudes. It is extremely difficult to teach this to house officers. Perhaps it can be learned only from observation and assimilation rather than by lecture. House officers must observe this relationship and activity as a daily part of their training. One problem with the current structure of our training programs is that there is no time for house officers to observe someone who has had extensive experience in this area. Their relationship is usually with an immediate superior in the hierarchy who generally is also just beginning to experience this phenomenon.

Indeed, it appears to me that death is a scene which most house staff and junior physicians avoid wherever possible; it makes them quite uncomfortable. If they cannot avoid it, they often launch into some degree of heroic activity, such as resuscitation or other maneuver, that provides an emotional escape for them and those around the patient. This activity usually does little for the terminally ill patient other than prolong a segment of unsatisfactory life for hours or days.

A third lesson for young physicians is that someone has to say, "We must allow this patient to die in a dignified manner; we have done as much as we can do to alter the disease process and have been unable to do so." Many physicians lack the emotional strength to accept this medical futility because they, too, have accepted mistakenly the idea they are to fight death and not disease. Many patients have exercised this responsibility as manifested by the growing popularity of advance directives. A great deal of agony and money

Dr. Cooper is past chairman of the Department of Medicine at Shadyside Hospital and past associate dean of the University of Pittsburgh Medical School.

might be saved if this concept of acceptance of inevitable death could be communicated to house staff.

A fourth point for house staff is that in most instances the patient is much better off knowing exactly what is wrong and what the outlook may be, rather than not knowing and feeling uncertain as to the outcome. With a few exceptions, the anxiety attendant upon the latter situation far exceeds that of knowing that one's life is soon to end.

Some people are emotionally unable to handle the knowledge of impending death despite the support from family, religious advisers, and physicians. If one can be sure of this, then the patient should not be told. On the other hand, if the patient indicates to you that he or she really wants to know exactly what is wrong and what the outlook is, the patient's questions should be answered with the utmost honesty throughout the course of the disease, despite the requests of other family members who feel that they may be "saving the patient from the knowledge."

This approach allows for the development of an excellent patient/attendant relationship and permits patient and family participation in decisions regarding potential therapy and its risks. This is the patient's right as an individual and is the basis of our concept of informed consent. We should see that the patient is allowed to exercise it.

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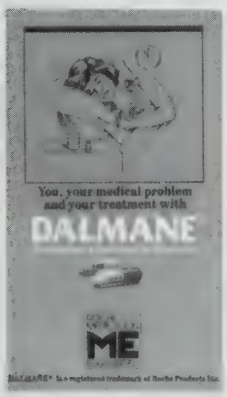
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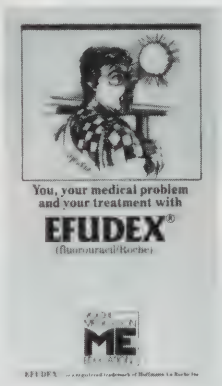
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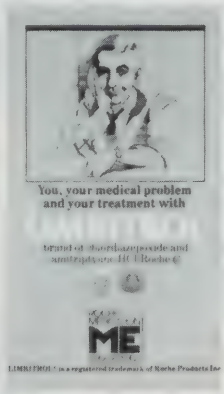
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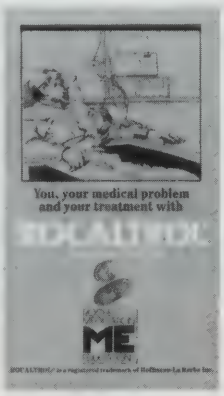
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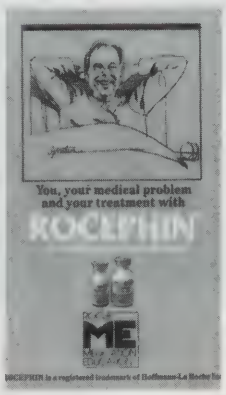
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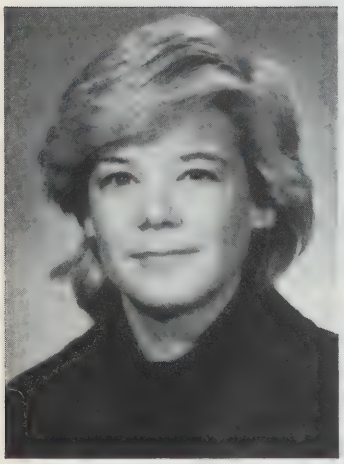
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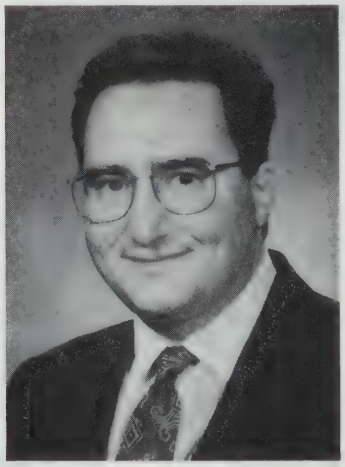
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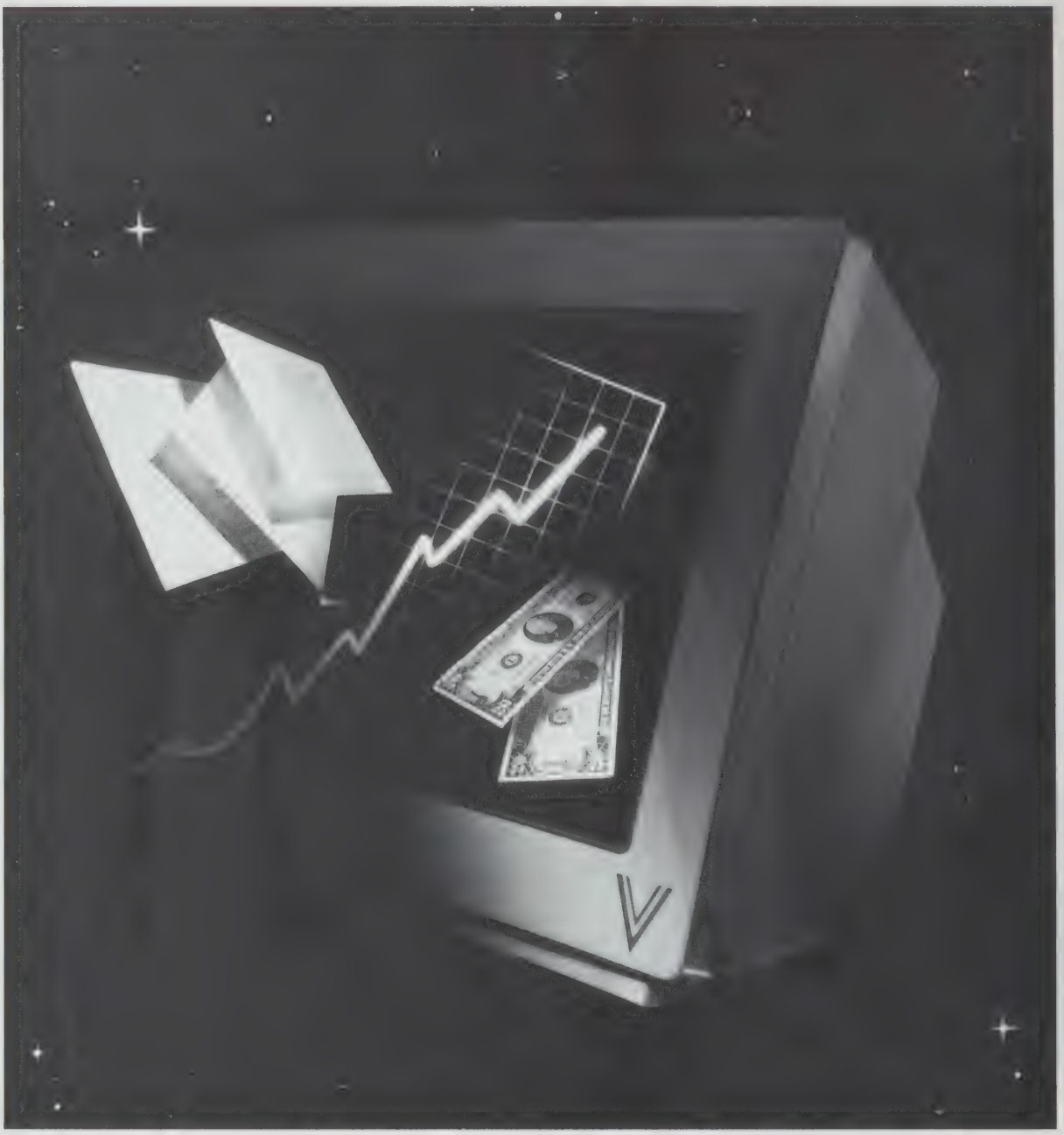
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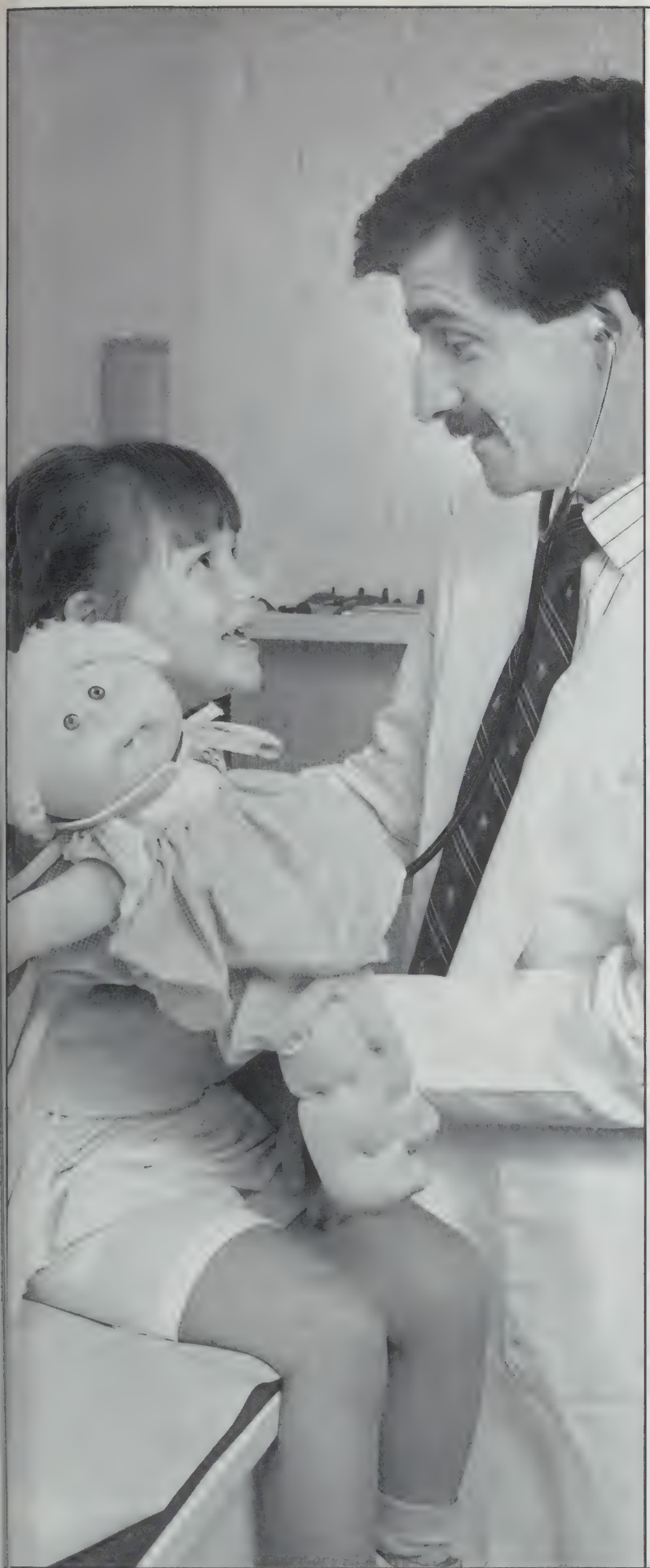
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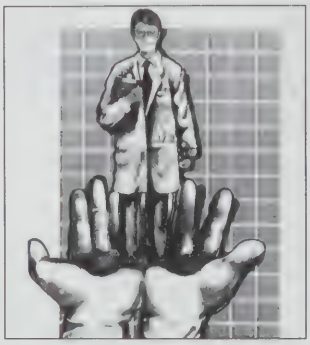
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Created by SpectraComp, Mechanicsburg (1-800-666-2662), on a Macintosh™ FX using Fractal, Inc.'s *Painter*™ and *ColorStudio*™ software, Adobe *Illustrator*™, and *QuarkXpress*™.

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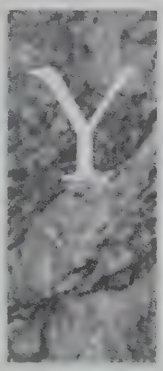
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PENNSYLVANIA MEDICINE (ISSN 0031-4595) is published monthly by the Pennsylvania Medical Society, 777 East Park Drive, Harrisburg, PA 17111.
SUBSCRIPTIONS: $20 per year— United States and Canada; $30—all others. Single issues $3.00 per copy prepaid; special issues cost more.
POSTMASTER: Send address changes to PENNSYLVANIA MEDICINE, 777 East Park Drive, PO Box 8820, Harrisburg, PA 17105–8820. Second class postage paid at Harrisburg, PA 17105.



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SOCIETY PERSUADES SENATE COMMITTEE TO CUT WORKERS' COMP LINK WITH MEDICARE: On April 6, the state Senate Labor and Industry Committee by a 9-2 vote amended House Bill 2140 to remove the proposed link of workers' compensation fees to the Medicare system. Contained in the amended bill are many provisions initiated by the State Society, including: use of the federal workers' compensation fee schedule, establishment of an annual inflation adjustment, and provision of procedural and peer review safeguards. However, the federal fee schedule was discounted more deeply than anticipated (to 80 percent). The Society is currently analyzing the impact of the discount. The Senate is in recess until early May. At that time the Society expects that attempts will be made to further amend the bill to restore Medicare language. Continued support of the Society's efforts is needed to achieve fair workers' compensation reform.

OSHA TO TEMPORARILY HALT ENFORCEMENT OF BLOODBORNE PATHOGEN STANDARDS: After a recent meeting with the AMA, the Occupational Safety and Health Administration (OSHA) agreed to temporarily halt enforcement activities under the "general duty clause" of new regulations on occupational exposure to bloodborne pathogens. Although the rule is not yet final, according to the AMA, OSHA had begun enforcement through such activities as inspections and audits of physicians' offices, and on an advisory basis had cited physicians for non-compliance. In its meeting with OSHA officials, the AMA requested several items. OSHA has agreed that until the new standard becomes final: 1) it will not cite physicians for violations; instead, initial enforcement efforts will be educational; and 2) it will refrain from performing any audits unless a complaint is received. The AMA will continue to pursue additional corrective actions.

INSERT DESIGNED TO HELP PHYSICIANS WITH OSHA IMPLEMENTATION: Included in this issue of PENNSYLVANIA MEDICINE is a pull-out insert designed to help physicians comply in a timely and effective manner with OSHA's new regulations on occupational exposure to bloodborne pathogens. The insert, "The New OSHA Regulations" (pages 28A1-4), discusses when requirements take effect, who's affected, what physicians must do to comply with the regulations, and what compliance will cost. An order form is provided at the end of the insert for a complete compliance kit, offered exclusively to Society members.

HCFA TO BILL LABS UNDER CLIA '88: On or about May 1, the Health Care Financing Administration (HCFA) will begin billing physicians for registration of office laboratories in accordance with new regulations under the Clinical Laboratory Improvement Act of 1988 (CLIA '88). Initial fees will range from $100-$600 depending on the type and quantity of testing accomplished. This information should have been reported to HCFA in a survey completed by affected physicians last January. While HCFA has established three complexity levels of testing, most office labs will fall into one of the first two. "Waived tests" include dipstick/tablet urinalysis, ovulation tests, urine pregnancy tests, nonautomated erythrocyte sedimentation rate, hemoglobin (copper sulfate), fecaloccult blood, spun microhematocrit, and blood glucose-monitoring devices cleared by the Food and Drug Administration specifically for home use. "Tests of moderate complexity" comprise about 75 percent of the remaining 10,000 testing procedures. HCFA has not yet published regulations detailing procedures for exempting state licensure programs, such as the one currently operated by the Pennsylvania Department of Health's Bureau of Laboratories. Physicians may, therefore, be required to follow both federal and state procedures in the interim. Look for comprehensive analyses of CLIA '88 in future issues of PENNSYLVANIA MEDICINE.

RBRVS VIDEO AVAILABLE: The State Society has developed and produced a videotape about Medicare payment reform and the resource based relative value scale (RBRVS). The 37-minute video is available from the Society for $19.95 plus tax, shipping, and handling. For information, call 1-800-228-7823.

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John W. Mills, MD
Medical Editor

Due to the short time between the Forum on Hazardous Waste Incineration sponsored by the Pennsylvania Medical Society and the deadline for this editorial, I haven't had time to review and digest all of the material presented at the forum. However, I feel compelled to let our readership know the gist of the forum and reaffirm the Society's position on hazardous waste incineration.

Essentially, hazardous wastes include toxic, flammable, explosive, and corrosive substances and *exclude* infectious, radioactive, and most solid wastes. The Society's policy statement, adopted by the Board of Trustees on January 30, 1991, recognizes that as Pennsylvanians produce such waste, we are also obligated to dispose of it in a safe and efficient manner. While the Society does not officially oppose development of hazardous waste incinerator facilities, its members agree that our job is to safeguard the health and well-being of persons working at and living near a facility: fumes, noise, dust, traffic, and emergencies have to be considered, as well as the impact on local property values and local emergency services.

"Nobody has the answers, so we'll most likely fumble along and learn as we go."

I was under the misconception that the federal Environmental Protection Agency (EPA) and the Pennsylvania Department of Environmental Resources (DER) had all the answers about the operation of hazardous waste incinerators and the health hazards of such facilities. But, *they don't!* While there is some data, it is in very general form and cannot be assumed for every possible incinerator site. The agencies have some very complex formulas to figure out almost anything concerning effects on rats and mice, but little to apply to humans. Additionally, *no* Pennsylvania-specific studies have been conducted at all.

Obviously, we're learning as we go—not exactly a safe way to do this. As one of the speakers at the forum, George Lumb, MD, an environmental researcher from Duke University, put it: "We are *crisis-oriented* in this country when it comes to waste disposal of all types;" and we are trying to solve issues overnight that we should have been dealing with since before World War II. Since that time, there has been an explosion of "disposable" and bubble-pack packaging materials—as well as throw-away cans and bottles—all in the name of efficiency.

This has spawned whole new industries and increased our waste immeasurably. It probably goes without saying that it has also increased the cost of materials we use packaged in such containers. There is no doubt that disposable items have made it much easier for the medical profession and health care facilities where laborious cleaning and sterilization processes have been replaced by disposables. And in light of the HIV problem, this is probably good. However, we do have a problem disposing of this "stuff," and we aren't doing a very good job of it in Pennsylvania. Dr. Lumb presented an interesting proposal: that generators of waste (e.g., industry) should come forth with a recycling plan to begin eliminating part of our problem.

There are no complete answers relative to hazardous waste incineration. Since we've never had such a unit in Pennsylvania, we don't have any experience. Other states have some experiences, but many are clouded in anecdotal stories by those who live near the facilities. And, scientific data speaks only to each specific facility and cannot be assumed as accurate for a Pennsylvania unit with different climatic conditions and terrain. Human data relative to the incinerators would be moderately accurate for plant workers, but not totally reliable for citizens living in proximity to a facility.

Nobody really has the answers, so we'll most likely fumble along and learn as we go. Perhaps the federal government should be more concerned about such serious issues instead of spending our money trying to determine what lab tests doctors do in their offices and whether physicians have invested in a medical facility in an effort to have one readily available for the convenience of patients and doctors.

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MIIX President

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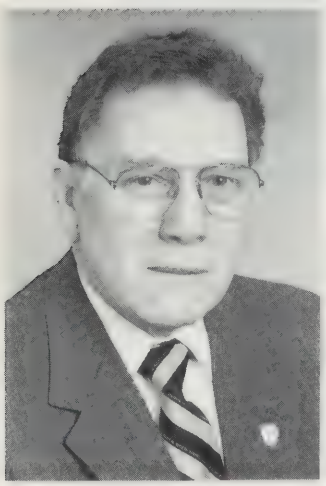
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Our Obligation to the Future

Robert N. Moyers, MD

"What we put into the (health care)system now will determine the effectiveness and strength of our profession in the future, as well as the health and well-being of the next generation of patients."



We often describe our concern for the health care system as one of balance: between cost, quality, and access. We have another concern of balance, as well: between the present and the future. No matter how great our concern for the matters of the moment, we in the Pennsylvania Medical Society are always mindful that we are also obligated to lay a sturdy foundation for the physicians and patients of the future.

There are signs that warrant our concern. Between 1986 and 1991, a 19 percent drop occurred overall in the number of medical students entering the specialties of internal medicine, family practice, and pediatrics. Similarly dramatic drops occurred in those entering and leaving medical school. Fewer incoming students express interest in primary care, and fewer graduates are planning careers in primary care fields.

Meanwhile, in parts of the country such as the rural areas of Pennsylvania, there is a shortage of primary care physicians. This undermines the effectiveness of our network of care. Our health care system serves our patients best when each patient has access to preventive care, as well as appropriate referrals to other practitioners in our community of caregivers.

For example, a family practitioner monitoring a patient's cholesterol levels may be a far more appropriate level of care than a cardiologist serving the same function. Yet, access may be the determining factor in the patient's selection of a physician. Thus, the cardiologist's time and skills are diverted from patients requiring more specialized care, and our physician network is not being used to the best advantage of all. The inappropriate selection by patients of certain specialists to provide basic health services leads to fragmentation of care and creates further disincentives for new physicians to seriously consider primary care.

Some might argue that, in a free society, the choice of medical specialty properly belongs to the individual, and attempts to influence that choice lead us down a road we do not wish to go: toward control of our profession, rationing of specialty positions, and loss of autonomy.

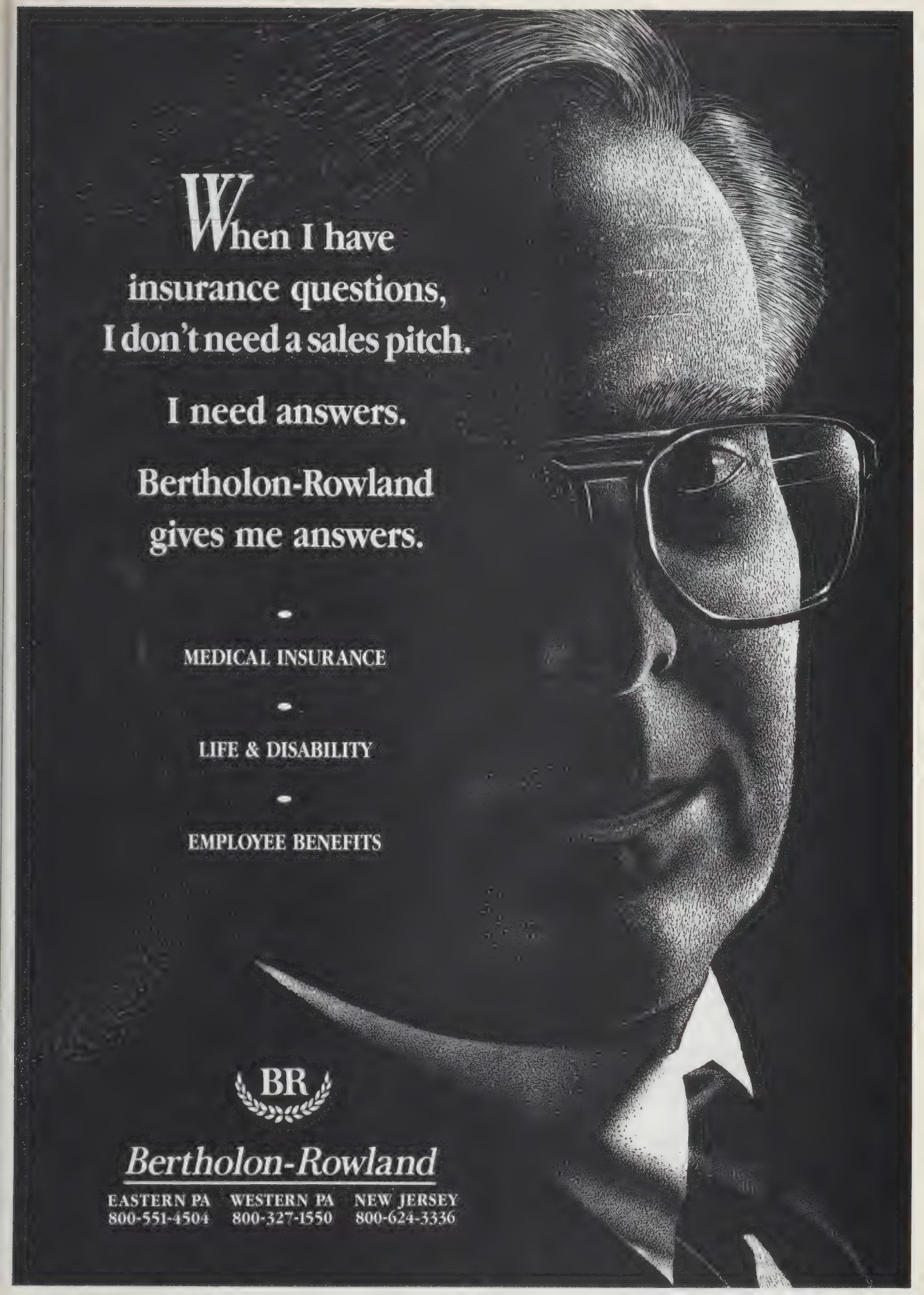
Without question, we respect the personal freedom of the individual practitioner and the academic freedom of our medical colleges and universities. We also must emphasize that no one makes decisions in a vacuum. We are influenced by many factors, including the availability of specific kinds of resources and the strength of our role models.

A recent survey shows that the medical schools with the greatest number of graduates entering primary care are those medical schools with departments of family medicine. The climate of our institutions and the quality of the options presented to the future physician cannot help but influence his or her selection of specialty.

When we look at the problems in today's health care system, we must see that they did not occur simply because of governmental interference or the proliferation of third-party payors, though these are certainly important contributors. We must also look at the make-up of our profession and how we, ourselves, have contributed to the problems of lack of access to primary care and growing health care costs.

In health care, as in the human body, everything is related. What we put into the system now will determine the effectiveness and strength of our profession in the future, as well as the health and well-being of the next generation of patients.

We must look at how we can encourage young people to consider dedicating their professional lives to those areas of medical practice where the need is great. We must look at how students pay for their medical education and how we can help. We must look at the resources available to our medical students and foster development in those areas where we see shortages of opportunity. And we must provide strong role models, advisors, and mentors for those who are asking the questions that only our experience can answer.


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LETTERS TO THE EDITOR

OPPOSING PHARMACISTS' USE OF DEA NUMBERS

A matter of considerable concern to me has not been resolved by the usual methods through the State Society. It is apparent that certain pre-paid prescription plans identify the prescribing physician by his or her DEA number. I became aware of this because I have been getting frequent calls from pharmacists requesting my DEA number, when in fact the prescription written was not for a narcotic. I have routinely refused to give that information and explained that there are many other ways to identify the ordering physician, not the least of which is using his or her license number which is on the written prescription. Apparently the pre-paid plans continue to request DEA numbers.

It occurred to me that none of my colleagues were complaining about similar requests from pharmacists, and I have concluded that since I, an ophthalmologist, rarely order narcotic prescriptions, my DEA number is not on file in many pharmacies. When I asked about similar calls with orthopedists, general surgeons, or other specialists, they said they are not bothered by such inquiries. On the other hand, narcotic prescriptions are somewhat commonplace from their offices.

I seriously question the wisdom of using DEA numbers as identification numbers for the purpose stated above.

It would seem that the State Society should act as a liaison with the pre-paid prescription plans in remedying this situation. I have discussed this with a local delegate who directed me to one of the administrative members of the Society staff, but obviously nothing has been accomplished. This recently came to a head when an irate pharmacist violently hung up the telephone while I was extending my reasoning to her.

I would be curious to hear how many other physicians in the state are getting similar requests from pharmacies. This practice is wrong and should be remedied.

Robert L. Shindler, MD
Camp Hill

Response: Thank you for bringing this matter to our attention. I agree that this is inappropriate. State Society staff have recently made inquiries about the use of DEA numbers by prescription plans. It was stated that pharmacists need a number universal from state to state for all physicians. Since medical license numbers are state specific, they are not sufficient. However, DEA numbers are not state specific. The prescription plan has agreed to consider alternatives to the use of the DEA number, such as Medicare's Unique Physician Identification Number (UPIN). Currently, Society staff members are pursuing that avenue.

John W. Mills, MD
Medical Editor

EDITOR'S NOTE

The Discharge Summary, "Family Unity: A Point of View," in the February 1992 issue of PENNSYLVANIA MEDICINE states:

We know that 65 percent of all children born in the United States are born of unwed mothers between the ages of 15 and 19. In Pennsylvania that figure is 78.5 percent.

The state Department of Health has requested further clarification of that paragraph as follows:

We know that in 1988, 67.4 percent of children born in the United States to women between the ages of 15 and 19 were, in fact, born to unmarried women. In Pennsylvania in 1989 that figure was 78.5 percent.

DEBATING "DISCIPLINE"

I write to object to the article entitled, "The Discipline of Destiny," by J. Mostyn Davis, MD, in the December issue of PENNSYLVANIA MEDICINE. Why was it written; who is to blame for its publication; and what, dear Lord, does it say?! PENNSYLVANIA MEDICINE owes its readers an answer to these simple questions: "What does it say? What does it mean?" If the answer is "nothing," the page should be left out. Let's save paper and the trees.

Daniel G. Lareau, MD
Warren

Editor's Note: The preceeding was excerpted from a lengthy, detailed letter. The following response, submitted by Dr. Davis, refers to the original letter in its entirety: "Every author cherishes the hope that the material they pen will be read by someone. I was pleased to note the article cited was read. In fact, 'The Discipline of Destiny' was read by Dr. Lareau rather carefully. Most authors do not appreciate critics who point out their deficiencies. However, I received three notes from doctors who reported they read the article with pleasure, versus one who was unhappy with it."

LIPID DISORDER TRAINING AVAILABLE

I completed a great training program this year, and through your publication I want to tell other physicians so they also can take advantage of it.

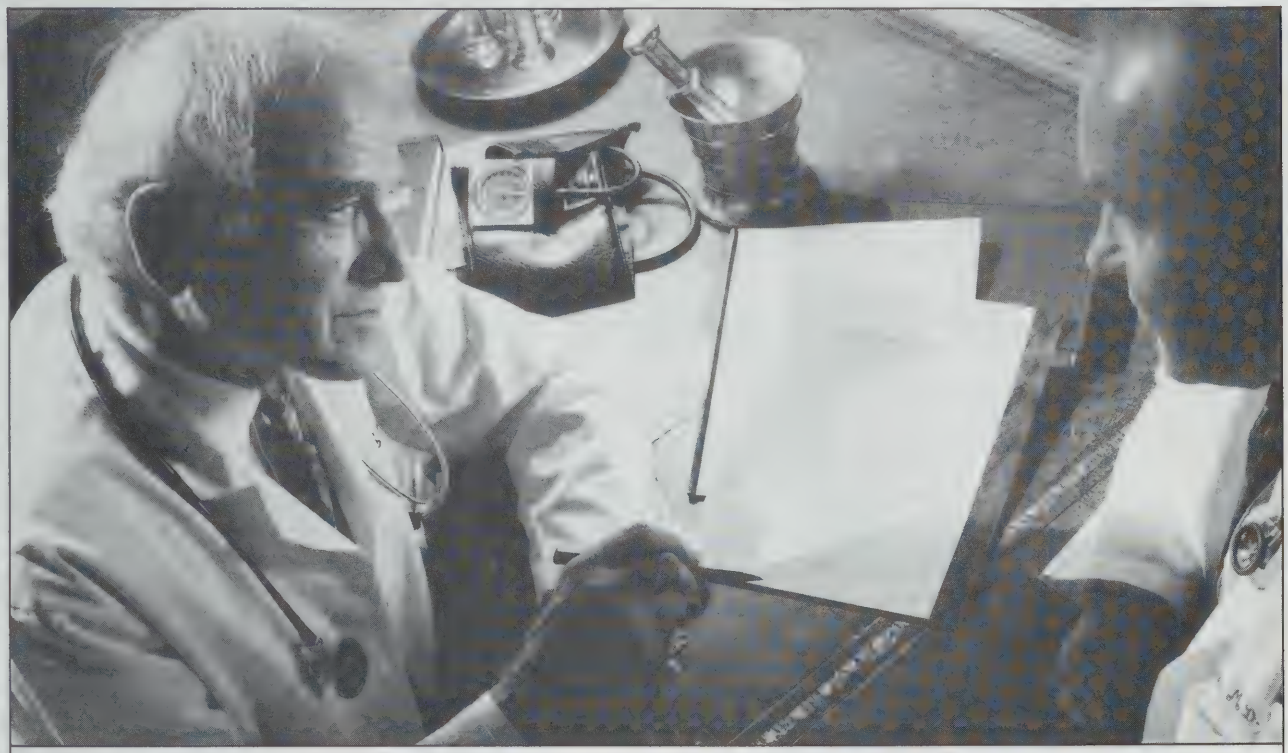
The small number of lipid specialists in the country, localized to university medical centers and large cities, cannot meet the growing demand for consultative services from primary care physicians when they encounter patients with complex lipoprotein disorders.

The Lipid Disorder Training Course, sponsored by the American Heart Association and a large pharmaceutical company, intensively trains intermediate-level clinical lipid specialists over a three-day period in six centers. These physicians then provide consultation and establish standards of practice for the treatment of these disorders at a local level.

I hope all physicians who have a bent in this direction can take advantage of this unusual opportunity for the benefit of themselves, as well as all of the patients who urgently need diagnosis and therapy of their lipid disorders. The course has expanded my practice in that area dramatically.

Harold V. Werner, MD
West Plains, Missouri

Editor's Note: The Lipid Disorders Training Course is held in six regional locations nationwide: Washington University, St. Louis, Missouri; Johns Hopkins School of Medicine, Baltimore, Maryland; University of Iowa, Iowa City, Iowa; University of Washington, Seattle, Washington; University of California, San Francisco and Berkeley, California; and Baylor University, Houston, Texas. For additional information, physicians in Eastern Pennsylvania should call Mary Anne Palmer at Johns Hopkins University, (410) 614-0485; and physicians in Western Pennsylvania should call Martha Stegmaier at Washington University, (314) 362-4442.



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New Employment Discrimination Law: Finally, Protection for Physicians!

Susan M. Weber, Esq.

The federal Americans with Disabilities Act provides employment discrimination protection for handicapped or disabled people. However, a Pennsylvania statute amended in 1991 provides startling new protection for physicians. This article is intended to address only the responsibilities of physicians as employers and their rights as disabled individuals under state and federal law; it is not intended to discuss patients' rights.

The Americans with Disabilities Act (ADA) provides comprehensive civil rights protections to individuals with handicaps or disabilities in employment, access to public accommodations, state and local government services, and telecommunications (see "The Disabilities Act: How to Comply" in the December 1991 issue of PENNSYLVANIA MEDICINE). However, the Pennsylvania Human Relations Act (PHRA) and the regulations promulgated pursuant to the act, which generally mirror the ADA, afford much broader protections in many ways.

For purposes of this article, unless otherwise noted, discussion of the provisions of the PHRA includes those of the ADA. Physicians should be aware of the mandates of these statutes because they affect physicians in three very distinct ways. Physicians have many roles in society, including those of employer, of physicians conducting preemployment physical examinations for other employers, and of independent practitioners of the healing arts.

Role as employer

The employment provisions of the ADA take effect July 26, 1992, for employers with 25 or more employees, and July 26, 1994, for employers with 15 to 24 employees. Thus, the ADA employment provisions will not affect employers with less than 15 employees. The PHRA, on the other hand, currently applies to employers with four or more employees, including those who work on a part-time basis.

The PHRA prohibits discrimination against individuals with non-job-related disabilities in any employment decision. Such decisions include advertising for applicants, hiring, firing, contracting with independent contractors, payment of compensation, tenure decisions, or decisions concerning any other terms or conditions of employment. The PHRA contains several exceptions. Its provisions do not apply to operation or terms of a bona fide retirement/pension plan or bona fide group/employee insurance plan, or to age limitations in apprenticeship programs. The PHRA affirmatively states, however, that uninsurability or the potential for increased insurance costs is not a basis for considering a disability job-related. In addition, employers may provide information to insurers for bona fide insurance purposes, and the act also permits religious associations or corporations to hire on the basis of sex where religious beliefs or practices require.

Similarly, the ADA permits religious groups to preferentially employ on the basis of religious affiliation. An employer may not, however, discriminate on the basis of disability provided the applicant meets the required religious criteria. The ADA further permits employers who establish, sponsor, observe, or administer insurance benefit plans to comply with "accepted principles of risk assessment," but they may not deny employment because of the possibility of increased insurance costs or potential for future complete disability.

While insurance policies may exclude pre-existing conditions, they may not be utilized as a basis for discrimination against a disabled employee. And finally, health insurance policies may limit coverage for treatment, even though such clauses may affect disabled employees.

Employers may not discriminate

Ms. Weber is assistant general counsel for the Pennsylvania Medical Society.

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ELECTRONIC SERVICES

In addition to individuals with disabilities, the PHRA provides protections to individuals on the basis of race, color, age (over 40), sex, national origin, ancestry, use of guide animals (either because the person is disabled in some manner or because the person is a trainer of such animals), and in some instances, familial status.

against qualified individuals with disabilities in employment decisions. The ADA defines a "qualified individual with a disability" as "an individual with a disability who satisfies the requisite skill, experience, education, and other job-related requirements" of the position and who, "with or without reasonable accommodation, can perform the essential functions of such position."

Essential functions include fundamental or critical functions, but not marginal ones. Also, functions may be considered essential to certain positions because of staffing considerations or because of the skill and training required for completion of the functions. Employers should review and revamp job descriptions so that essential functions can be easily discerned and marginal functions reassigned if need be.

While the PHRA does not define "qualified individual," both acts require an employer to provide "reasonable accommodation" to employees or potential employees. Reasonable accommodation may include: altering the application or interview process; modifying time schedules to accommodate rest requirements or physician visits; providing braille equipment, qualified readers, or reading machines for vision-impaired employees; providing interpreters or telephones specially equipped for hearing-impaired employees; or reassigning employees to vacant positions if necessary.

Reassignment need be an option only if vacant positions are available; an employer is not required to create a new position if a disabled employee is unable to perform the essential functions of his or her current position. The employer is required to consult with the employee or applicant in determining which accommodations would be most appropriate. The employer must not force an applicant or employee to accept accommodations, as the acts permit a disabled person to refuse such aid. However, should the applicant or employee refuse and because of the refusal is unable to perform the essential functions of the position, he or she will no longer be considered a "qualified individual with a disability."

An employer may require that an applicant's or employee's disability not pose a "direct threat" to the health or safety of himself, herself, or others and is required to offer reasonable accommodation if doing so would eliminate or reduce the risk to acceptable levels. However, the risk of harm must be "substantial" and not "speculative or remote." The magnitude of this risk is determined individually based on

Who is protected under the ADA?

The Americans with Disabilities Act (ADA) protects several classes of individuals:

- those who have "a physical or mental impairment that substantially limits one or more of the major life activities,"
- those who have a record of such an impairment, and
- those who are regarded as having such an impairment.

The phrase "physical or mental impairment" encompasses a wide variety of physiologic conditions, disorders, and chronic diseases; anatomic losses; psychological disorders; intellectual deficiencies and learning disabilities; HIV disease, either asymptomatic or symptomatic; drug addiction; and alcoholism. "Major life activities" include "caring for ones 's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working."

In protecting people who have a record of an impairment, the Act includes not only those who have a history of such an impairment and have recovered, but also those who have been misclassified as having such an impairment. The third category of protected individuals, those who are regarded as having an impairment, has several components: people who have impairments which do not substantially limit major life activities but are treated by private entities as if they do, those who have impairments which result from the attitudes of others, and those who have no impairments but are treated by private entities as if they were impaired.

The Act further protects those who have a relationship or association to an impaired person, including entities as well as individuals. Therefore, a physician could not lose his/her lease for treating patients with mental disorders for HIV, and an entity which provides an assisted-living facility for mentally retarded people could not be evicted for doing so. The Act provides a cause of action for this individual or entity independent from that of the person(s) with impairments.

Congress excluded the following from coverage under the ADA: behavioral disorders such as compulsive gambling, kleptomania, and pyromania; sexual disorders such as transvestism, pedophilia, exhibitionism, voyeurism, and gender identity disorders; transsexualism; homosexuality or bisexuality; and "psychoactive substance abuse disorders resulting from current illegal use of drugs." Thus, while homosexuality is not protected, homosexuals who are HIV positive, or who are perceived as being HIV positive are protected. Similarly, people who are addicted to drugs or who have a history of drug addiction are protected while those who currently use illegal drugs are not.

objective, factual evidence regarding: the nature and severity of the potential harm, its duration, the likelihood that the harm will occur, and the imminence of the potential harm.

The acts do not require reasonable accommodation that would cause "undue hardship" to the employer. The ADA defines undue hardship as "significant difficulty or expense." While the PHRA does not specifically define the term, both acts provide non-inclusive examples of factors which should be taken into consideration when making a determination of undue hardship. Such factors include, but are not limited to: overall financial resources; impact on the employer's business and other employees; and the extent, nature, and cost of the accommodation.

Employers' actions may be suspect at all phases of employment decisions. Prior to an employment offer, both statutes prohibit any inquiry as to whether an applicant has a disability or handicap, or as to the extent of such disability. Employers may ask whether an applicant can perform the essential functions of a position, with or without reasonable accommodation. Employers may even request a demonstration of this ability, but only if an obvious or known disability is present which may hinder performance of job functions, or if employers make the same request of all applicants. In addition, pre-employment testing may not discriminate against or screen out applicants with disabilities.

Pre-employment medical examinations are prohibited unless and until the employer has extended a job offer. Final approval for the employment of the applicant may be contingent upon the results of the examination provided that all applicants in the same job category are subject to the same contingency. The examination need not be job-related, but employment decisions must be based only on job-related necessity. Any information obtained through such medical examination must be treated as a confidential medical record, and the record must be segregated from other employment records. The information must not be shared with anyone, except that: first aid and safety personnel may be notified for potential emergency treatment purposes, supervisors may be notified regarding the extent of work restrictions or accommodations required, and government investigators may be provided information upon request.

The medical examination prohibitions apply equally to treatment of employees. Employers may only require job-related medical examinations which demonstrate whether, with or without reasonable accommodation, an employee can perform the essential functions of a position. Employers are required to segregate medical records and may only disclose confidential medical information as described above. Employers may, however, offer voluntary medical examinations as part of an employee health program, provided that employment decisions are not based on non-job-related information, and the medical records are segregated and treated in a confidential manner.

Drug testing of employees for illegal drug usage screening is not considered a medical examination and is specifically permitted. Further, employers may institute drug- and alcohol-free workplace policies. It must be noted, however, that while the ADA protects those who have successfully completed or who are enrolled in a drug rehabilitation program, as well as those with alcoholism, employers may hold these employees to the same performance and testing standards as other employees.

The PHRA specifically excludes "current, illegal use of or *addiction to* a controlled substance" (emphasis added) from the definition of "handicap or disability." Since this exclusion appears in the December 1991 amendments, regulations promulgated thereunder have not yet been published. Even though the amendments appear to exclude those who are addicted but under treatment or who have successfully completed a rehabilitation program, Elisabeth S. Shuster, Esq., chief counsel for the Pennsylvania Human Relations Commission, has stated that the commission intended that PHRA amendments track the ADA's nonprotection of only current, illegal use of drugs and that forthcoming regulations will be explanatory.

Physicians should review their hiring, advancement and record-keeping policies and practices for consistency with the ADA and PHRA in order to minimize liability exposure.

The PHRA essentially tracks the ADA accessibility provisions (see "The Disabilities Act: How to Comply" in the December 1991 issue of PENNSYLVANIA MEDICINE). Physicians are reminded that the PHRA applies to all employers with four or more employees; they should review their policies, practices, and procedures for consistency with both the ADA and the PHRA.

Role in conducting pre-employment physical examinations

Physicians are often retained by other employers to conduct pre-employment physical examinations. As described above, employers may only require a pre-employment physical if a job offer has been tendered and if all applicants for the job category are treated equally. The physician's responsibilities in conducting such exams are limited to whether the appli-

cant can perform the essential functions required by the position, with or without reasonable accommodation.

While it may be necessary to elicit medical history information from an applicant in order to conduct a thorough examination, the physician must base the decision whether the applicant can currently perform the essential functions of the position only upon job-related information. A prudent approach would dictate that, for pre-employment purposes, the physician conduct a limited examination based on the responsibilities of the position so that any opinion with respect to fitness for duty would be based solely on whether the candidate could currently perform the essential functions of the position. Therefore, the physician's opinion would be based solely upon untainted information. A second, more thorough examination, which could include medical history information, could be conducted after the candidate's employment has been confirmed. Such an approach protects both the physician and the employer from future allegations that the physician's opinion as to whether the candidate was fit for duty was based upon information proscribed under either the ADA or the PHRA.

"... hospitals may not refuse, suspend, revoke, or even limit privileges based on a physician's HIV status."

Role of independent contractor

It is likely that physicians who are employed by hospitals or other employers are protected by the provisions of both the ADA and the PHRA. However, the PHRA amendments, which the General Assembly enacted in December 1991, go beyond the ADA and protect those physicians who are engaged independently in the practice of medicine. The amendments define "independent contractor" as "any person who is subject to the provisions governing any of the professions and occupations regulated by State licensing laws enforced by the Bureau of Professional and Occupational Affairs...." The provisions of the PHRA which protect the employment status of employees also protect the independent contractor status of the physician.

Therefore, hospital medical staffs to which a physician seeks privileges cannot refuse to contract with, bar, or discharge (if privileges have previously been granted) from the staff or otherwise discriminate against a physician who has a handicap or disability, if that physician is the most competent person to fill the available position. Because the PHRA has, since 1986, recognized a positive HIV status as a handicap or disability, an HIV-positive physician is protected from discrimination in medical staff relationships.

Hospitals may not advertise their preferences or limitations with respect to HIV status or other disabilities when they seek to fill medical staff positions. In addition, they may neither inquire nor utilize application forms which request information concerning an applicant's HIV status or other disabilities. They may not ask, at any point in the application or credentialing process, whether or not a physician is HIV-positive. Hospitals may only ask whether a physician can perform the essential functions required, with or without reasonable accommodation.

Furthermore, hospitals may not refuse, suspend, revoke, or even *limit* privileges based on a physician's HIV status. Current regulations prohibit the termination, alteration, or limitation of employment, and therefore, in the context of physician-independent contractors, privileges, because a non-job-related condition may progress and become job-related at some point in the future. Pennsylvania federal courts have held that any decisions as to job-relatedness must be based upon "objective, individualized, and medically valid evidence." Regulations further provide that a "handicap or disability may be job-related if placing the...applicant in the job would pose a *demonstrable* threat of harm to the health and safety of others" (emphasis added). *No physician, to this date, has communicated the HIV virus to any patient.*

In addition, neither the Centers for Disease Control nor any research team has stated unequivocally that an HIV-positive physician, who appropriately utilizes universal precaution techniques, is likely to infect patients. Unless and until such time, an HIV-positive status cannot be considered, by any medically valid evidence, a demonstrable threat of harm and therefore a job-related disability for which a physician can be denied privileges or have privileges limited in scope. Under Pennsylvania law, this analysis applies to all physicians, including surgeons.

The PHRA states that its provisions do not apply when a bona fide occupational qualification requires otherwise. While some would argue that a surgeon must be HIV-negative as a bona fide occupational qualification, regulations prohibit this analysis. In order to demonstrate a bona fide occupational qualification which would permit discrimination against a physician who is HIV-positive, a hospital must "prove a *factual* basis for believing that all or substantially all members of a class covered by the act would be unable to perform safely and efficiently the du-

ties of the job involved" (emphasis added). Based on current factual medical knowledge, it is unlikely that hospitals would be able to meet this requirement.

While the PHRA provisions and its interpretive regulations could be challenged in the Pennsylvania courts based on public policy reasons, until such a challenge is successful, hospitals must conform to the language of the act.

Finally, hospitals may not deny any physician a position on a medical staff because of a past handicap or disability. Therefore, hospitals may not deny privileges because of previous treatment for a mental disorder if the applicant can presently perform the essential functions required. In fact, hospitals are required to provide reasonable accommodation, should the need arise, unless to do so would cause undue hardship.

With the exception of the PHRA's protection of physicians who practice medicine as independent contractors, a physician or an employee who believes he or she has been subject to discrimination based on a handicap or disability could file a complaint under either the PHRA or the ADA. Based on the facts of individual cases, relief allowed under the acts differ, as do administrative requirements. Therefore, someone in this position should seek the advice of counsel as soon as possible.

Assuring Accessibility

Physicians are required under the ADA and the PHRA to assure that their offices are accessible to the handicapped and to offer "reasonable accommodations" to their patients who are disabled. Beware of groups claiming to be "ADA certified" who offer consulting services for a fee. No such certification exists.

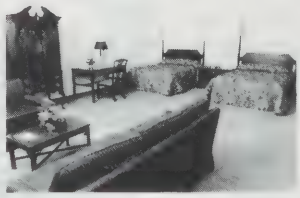
Utilize community resources, such as local branches of disability groups, for office evaluations. Ask patients with disabilities for their input with regard to accessibility of your office. But if you do so, remember to ask several with different disabilities, so that your office is accessible to patients with all types of disabilities.

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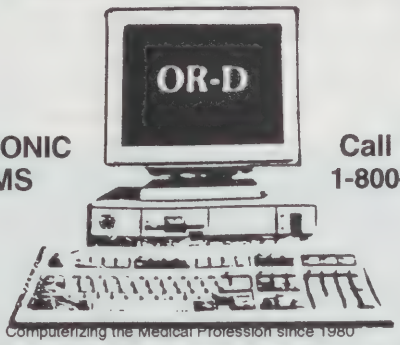


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WORKERS RALLY FOR COMPENSATION REFORM

"Healthy Worksite/Healthy Workers" was just one of several slogans floating around the Capitol in Harrisburg on March 9, when more than 550 physicians and hospital workers rallied for workers' compensation reform.

The effort began at the Hilton Hotel and Towers in downtown Harrisburg, where representatives of the Pennsylvania Medical Society, the Pennsylvania Osteopathic Medical Association (POMA), and the Hospital Association of Pennsylvania (HAP) convened. The crowd was welcomed by Robert N. Moyers, MD, president of the State Society, and John A. Russell, president of HAP. Jerry Rothenberger of the Society and Jim Redmond of HAP briefed the group on the day's activities and goals.

At 12:30 p.m., the physicians and hospital representatives marched through downtown Harrisburg and up the Capitol steps, and assembled inside the rotunda for a press conference. Dr. Moyers and Mr. Russell cited opposition to efforts to link medical reimbursement under workers' compensation to the Medicare payment system and presented the Society's and HAP's proposal for workers' compensation reform. The proposal would provide the following:

- a fee schedule for health care providers other than hospitals, based on the federal workers' compensation fee schedule with appropriate updates (known as OWCP or FECA);
- a payment system for hospital services calculated on the basis of a cost-to-charge ratio;
- a coordinated care organization option affording the opportunity for negotiation of rates and services between employers and groups of health care providers; and
- a streamlined claims submission and adjudication process, utilizing uniform claim form(s), uniform coding of services, clear requirements for supporting documentation of services, etc.

After the 20-minute press conference, the physicians and hospital representatives dispersed to meet with their state senators and representatives to further promote the alternative proposal. Although the event attracted media attention, no specifics about the impact of the day's activities are available as of this printing.

CASEY PROPOSES ABOLISHING HCCCC

The governor has proposed, through the budget process, to abolish the state's Health Care Cost Containment Council (HCCCC) as an independent agency and shift some of its duties to the Insurance Department. Such legislation, now being drafted by the Casey administration, is consistent with State Society policy, which opposes re-enactment of the HCCCC law and supports allowing it to "sunset."

Should the legislation pass, only the "core" duties of the council would be transferred to the Insurance Department, according to Insurance Commissioner Constance B. Foster. Topping that list would be development of an annual report on the cost and quality of hospital medical procedures around the state. Agency duties, such as reviewing mandated benefits and issuing new categories of reports on medical costs in Pennsylvania, would not be transferred and thus would be dropped altogether.

Should the governor's proposed legislation not move or pass, funding for the council will remain a budget issue for the next fiscal year.

COMMITTEE BEGINS REFORM DISCUSSIONS

Just three days after President George Bush unveiled his plan for comprehensive health care reform for the nation, the State Society's Committee on Long Range Assessment began its discussions about this national issue. The committee was charged last November with developing the Society's response to both state and federal health care reform movements.

During the meeting, John Gaffney, PhD, director of the AMA's Office of Strategies, Policy Planning, and Analysis, outlined the many reform models under consideration on state and federal levels. Committee members agreed the Society must move quickly to formulate an official response. Two meetings were held earlier this month to begin defining that response.

SENATE BILL AFFECTS MEDICAL STUDENT LOANS

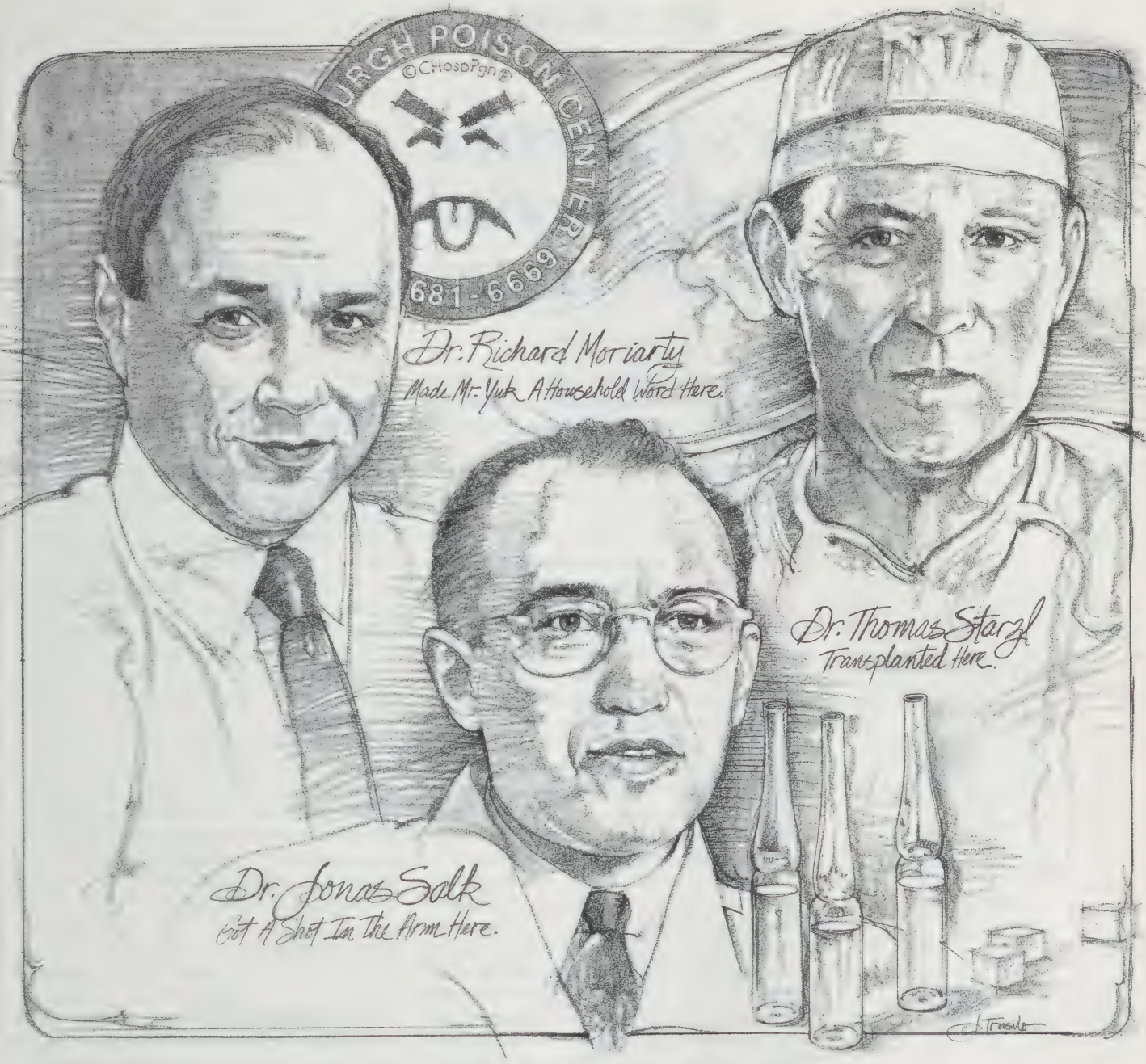
A bill to reauthorize the Higher Education Act passed the U.S. Senate in February on a vote of 93-1. Senate Bill 1150, based on a Labor and Human Resources Committee package of amendments, includes provisions to eliminate resident physician student loan deferments available under current law.

The amendments allow medical residents who have already taken out student loans to use the current two-year deferment option. But, elimination of automatic deferment would occur for new borrowers as of July 1, 1993; and after that date, deferment would be limited.

The U.S. House of Representatives was expected to consider House Bill 3553, its version of the Higher Education Act reauthorization bill, before April 11.



Following a march through downtown Harrisburg, more than 550 physicians and hospital workers gathered in the Capitol rotunda to support an alternative to the governor's proposed workers' compensation reform plan.



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Let's Practice Malpractice Prophylaxis

George J. Paul, MD

There are some subjects which cannot be reviewed often enough; and malpractice prophylaxis is one such subject. In spite of numerous articles which appear in our professional literature, the problem still haunts us.

What can be done about medical liability? Why is it still an on-going, major problem? Who is to blame for the current crisis? The doctors? The patients? The lawyers? Obviously all three are at the heart of this insidious dilemma.

Since we have no control over the legal profession and can affect the patient element only peripherally by behavioral persuasion, the answers must come from us, the physicians. And make no mistake about it—we can prevent, easily enough, the vast majority of malpractice cases!

Because of my 35 years of surgical involvement, including 15 years as chief of surgery and clinical professor of surgery, I currently act as surgical consultant to the law firm which handles malpractice defense for the Pennsylvania Medical Society Liability Insurance Company. I review records, charts, data, and other pertinent sources of information; analyze them; and make recommendations to either settle the case out of court or proceed with preparations for defense at a trial.

From my years of experience, it is obvious to me that the vast majority of malpractice cases brought against physicians can absolutely be prevented if doctors pay attention to nine specific areas. Malpractice prophylaxis consists of giving careful attention to: handwriting, progress notes, orders, daily visits to hospitalized patients, consultations, informed consent, complications, family and patient relations, and communication.

Handwriting

There is nothing more detrimental to the defense of a physician in a malpractice action than poor, illegible handwriting in hospital or office records. Of the thousands of records I have examined over the years, minimally 90-95 percent of them contain at least one or more entries that *cannot be clearly read or understood*. There are also many charts in which every handwritten entry is illegible: no order, progress note, or consultant's report can be deciphered or clearly understood.

There is no doubt in my mind that illegible charts pose the greatest challenge in the preparation of a malpractice defense effort. And the sad part of the story is that the physician who wrote the entry, when shown the chart in the defense attorney's office, often cannot read his own handwriting!

Illegible records open the door for the plaintiff to misinterpret or misrepresent the meaning or intent of an entry. Illegible handwriting most often presents an unsurmountable obstacle to the proper preparation of an adequate defense on behalf of the physician, should a patient or family choose to bring suit.

Progress notes

In order to have any validity at all, progress notes must be legible, timely, reflect the status of the patient, and convey real information to the reader. The sad fact is that most progress notes are absolutely worthless. They are illegible, undated, and do not note the time they were written; do not significantly review the patient's status; do not reflect any treatment plans; make no reference to data supplied by nurses, consultants, or a laboratory; and, if signed, are so illegible that no one can tell who wrote them.

All notes must be dated and timed as to when they were written, and they must convey information. I recently found the following series of progress notes in a hospital chart:

1/21—Surgery successful
1/22—Doing O.K.
1/23—Status quo
1/24—Status quo
1/25—To I.C.U.
1/26—In I.C.U.—unchanged
1/27—Notified family of death

Dr. Paul, retired from active practice, is emeritus chief of surgery at St. Luke's Hospital in Bethlehem and emeritus clinical professor of surgery at Temple University School of Medicine. He currently resides in Allentown.

Needless to say, after the family filed "an unnecessary and negligent death" action for alleged incompetent post-operative care, it was impossible to prepare an adequate defense, and I recommended settlement rather than trial.

Orders

Orders, like progress notes, are key elements in reflecting proper care of the patient. Orders should also be legible, dated and timed as to when written, and clearly state the dosage, mode, and frequency of administration. Medication errors can often be disastrous, but well-written and pertinent orders can protect the physician.

A recent case hinged upon the exact time a physician recognized a patient's status change and how long it took the physician to order proper medication to correct the situation. The plaintiff charged the physician with an inordinate delay of more than four hours, thereby leading to irreversible damage to the patient. The physician claimed the order was promptly and correctly written, and any delay was caused by failure of the charge nurse to pick up the order in a timely fashion. The trouble was that the time was not noted on the order, and the nurse claimed she promptly picked up the order after it was written by the physician. Who was telling the truth? It will now be up to a jury to decide. To make matters worse, there is no timed progress note entry to help the physician in his claim.

Daily visits to hospitalized patients

Hospitalized patients have a right to expect to be seen at least daily, and even more often if their condition or status so warrants. Nothing makes a patient feel more helpless or vulnerable, or gives them a greater sense of abandonment, than the failure of a physician to make *meaningful* daily rounds. The patient must be seen, examined, talked to, reassured, and convinced that the physician truly cares about him or her and has the situation well in hand. And remember, these daily visits must be backed up with adequate and meaningful progress notes. As far as insurance companies, governmental agencies, and lay juries are concerned, no progress notes means no visits were made; and no visits means no caring by the physician!

Consultations

In this day and age, with the public's high expectations about the quality of health care, it behooves all physicians to make adequate, proper, and judicious use of consultants. The public expects it, and the practice of modern medicine and surgery demands it. The surgeon who operates on a patient with a history of a recent myocardial infarction ought to arrange for a cardiologic consult before surgery and continued follow-up afterwards; the internist who admits a massive G.I. bleeder ought to set up an immediate surgical consultation for the patient; surgical patients with C.O.P.D. may well need the services of a pulmonologist; and a nephrologist may be useful in the care of a septic patient with partial or total renal shutdown, and this same septic patient should also be seen by the infectious disease specialist.

Medical practice today is really "team practice." We must put ego feelings aside, and obtain any and all necessary help we deem proper for the competent care of each and every patient. The public is very aware and sophisticated concerning the kinds of help available from subspecialists. They expect the help to be rendered. If it is not, they tend to agree with the plaintiff's claim that damage was done due to "failure to provide proper available consultative and specialist care."

Informed consent

Many physicians still fail to understand the potential malpractice exposure inherent in failure to personally obtain an informed consent from the patient (and often from the family). Regardless of hospital rules, I have made it a long-standing practice to obtain an informed consent for every invasive or out-of-the-ordinary procedure I perform on a patient. Please note that I say "personally obtain" the consent—not by the nurse or the resident or the desk clerk. When I personally obtain the consent, it gives me an opportunity to talk about and explain the situation to the patient. It helps foster goodwill, trust, and confidence between the patient and the doctor, and it ensures that the patient really does know what's happening.

I reviewed a litigation case where the consent for major surgery was obtained from the patient by the charge nurse. Post-operatively, the patient was devastated to find that a permanent ileostomy had been performed on him. In court, the patient stated he would never have consented to the surgery had he been told of the ileostomy. The defendant surgeon ad-

"Medication errors can often be disastrous, but well-written and pertinent orders can protect the physician."

mitted that he had not personally obtained the surgical consent, but had ordered the nurse to do so. The nurse was not fully aware of the extensiveness of the patient's ulcerative colitis, nor of the premalignant changes already present in the patient's bowel. The surgeon stated he assumed all patients with long-standing, extensively treated colon disease would know that kind of colon pathology would require a total colectomy and permanent ileostomy. Needless to say, the jury found for the plaintiff.

As stated before, the physician should obtain consent for any and all procedures, even those considered "routine." You never know when a sigmoidoscopy or colonscopy will lead to a colon perforation, or a subclavin vein catheter insertion will lead to a massive pneumothorax requiring placement of a thoracostomy tube or resulting in a brachial plexus injury. When the physician personally talks and explains the situation to the patient and the family, the physician is performing the best kind of malpractice suit prophylaxis there is in case something does go wrong.

"When the physician personally talks and explains the situation to the patient and the family, the physician is performing the best kind of malpractice suit prophylaxis there is . . ."

Complications

The occurrence of complications is inevitable. They happen all the time, but are usually successfully handled and resolved. The patient and family should always be notified of all complications. The physician should explain what happened, why it probably happened, what was done to correct the situation, and how the complication might affect the patient's prognosis.

Usually a frank discussion with the patient will allay the usual concerns and will serve as a reassurance to all. Even if the physician tries to get away without telling the patient, the grapevine at hospitals is such that sooner or later the patient and family discover the truth. They then may well develop a mistrust of their physician, which can effectively destroy all goodwill and rapport, and make them view all future untoward incidents with apprehension and suspicion.

Family and patient relations

It is important that a cordial, forthright, caring, trusting, and thoroughly professional relationship be established and maintained between physician and family. The better the relationship, the more tolerant the family will be in the event untoward or unfavorable results occur. Malpractice suits are often instigated by disgruntled patients and families who are convinced that "the doctor didn't give a damn about what happened."

The physician can be thought of as both a friend and a highly regarded professional by the family. They both truly go hand-in-hand. The physician's caring attitude helps cement the bonds of a cordial and correct relationship, and leads to trust and cooperativeness by patient and family.

Communication

Basically, at the heart of these "prophylaxis pointers" is *communication* between all parties concerned. By the written and spoken word, body language, gestures, and all other means and modalities, the physician must convey to the patient and family a caring attitude, and I mean one that clearly and truly shows he or she cares about the patient; knows what's going on; will do the very best to competently care for and treat the patient; will respect the wishes, beliefs, and feelings of the patient; and will openly and truthfully discuss anything and everything with them. Too often, the patient and family are "the last to know." Therefore, the physician must talk to them frequently, telling them the current status of the patient personally, rather than through an intermediary. We must always be aware of how stressful and frightening an illness can be, and how important and comforting it is when the physician communicates and empathizes with the patient and family.

Conclusion

Will the above nine prophylactic points prevent malpractice suits? Of course not! But they will stop many of the small and petty actions taken by patients as a means of "getting even with the doctor" for perceived (or actual) slights and mishaps.

The physician, through these actions, can help make the patient more understanding and aware of the fact that the practice of medicine is a blend of both art and science, and all sorts of things—complications, untoward and unexpected reactions, failure to respond to treatment, even death—can and do happen! The bottom line to this whole essay is to tell you a simple truth: it is much harder to sue a sympathetic, caring, and trusted physician-friend than an uncaring stranger.

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Medical Practice Consult: Coding

This is the first installment of a continuing column designed to answer physicians' questions about specific third-party reimbursement and other timely practice management issues physicians face daily in medical practice. State Society members are encouraged to submit questions, typed on letterhead, to: Medical Practice Consult, Department of Physician Services, Pennsylvania Medical Society, 777 East Park Drive, P.O. Box 8820, Harrisburg, PA 17105-8820. Answers will be solicited from the Society's Practice Management Consulting Network, a group of eight consulting firms in various areas of health care expertise. Answers to the following questions were submitted by the Health Care Group, Plymouth Meeting, (215) 828-3888.

Should terms such as "rule out," "probable," and "suspected" be used when coding for diagnoses?

Physicians must often wait for test results in order to confirm a suspected diagnosis and will usually indicate suspicions by use of such terms. While these unconfirmed diagnoses are acceptable in chart documentation, they should be ignored when coding diagnoses. Until a definitive diagnosis has been determined, the patient's signs and symptoms should be coded.

When a patient presents to the office with a cough, fever, and rales, several diagnoses may be applicable. Until a diagnosis had been confirmed, the appropriate codes to use are 780.6 for fever, 786.2 for cough, and 786.7 for rales.

All information provided to carriers becomes a part of the patient's record. An unconfirmed diagnosis that is eventually ruled out will remain on a patient's record and may create a problem in the future, e.g., when the patient applies for life insurance or has medical benefits denied because of a "pre-existing condition."

Please explain the proper use of "V" and "E" codes.

ICD-9-CM "V" and "E" codes are supplementary classifications of the factors influencing health status and contact with health services, as well as external causes of injury and poisoning. "V" codes address circumstances, other than a disease or injury classifiable to codes 001-999, recorded as "diagnoses" or "problems." These codes are used in the following three circumstances:

1) When a person who is currently not sick requires health services for a specific purpose (e.g., V07.2, prophylactic immunotherapy, is used when a person has been exposed to hepatitis and requires inoculation).

2) When a person with a known disease or injury is receiving a specific treatment for that disease (e.g., V67.0 is a follow-up examination after surgery).

3) When some circumstance or problem is present which influences a person's health status, but is not a current illness or problem (e.g., V17.3 is used for family history of Ischemic heart disease).

The third circumstance requires the use of the "V" code and the diagnosis code for health services provided. While these codes are accepted by most third-party payors, they do not guarantee payment for services. In order to receive reimbursement from payers like Medicare, Medical Assistance, and Blue Shield, "V" codes should generally be used as the secondary diagnosis with a numeric code as primary.

"E" codes identify the environmental events, circumstances, and conditions that surround a specific illness or injury, and may not be used alone. If a person fractures the fibula as a passenger in a car involved in an accident, E813.1 would be coded along with the fracture diagnosis. These codes are often required for workers' compensation and liability claims.

Can I bill for holiday service in addition to basic service?

Code 99054, for services requested on Sundays and holidays in addition to the basic service, is available in the Special Services and Reports section of the *CPT* book. This code allows the physician to bill for the aggravation of having a holiday interrupted in addition to the basic service provided. For example, if a patient requests an office visit on Christmas Day for a sore throat, the physician would bill for the appropriate visit level for office services and code 99054 for seeing the patient on a holiday. Be aware that few third-party payors allow reimbursement for these codes; therefore, the patient will usually pay out-of-pocket for the service. Also, Medicare and Medical Assistance patients should *not* be charged for these services.

Please specify when "critical care" and "prolonged care" should be used in coding for services.

As a result of the changes in evaluation and management codes, new critical care codes now exist: 99291 critical care, first hour; and 99292 critical care, each additional 30 minutes. Critical care follow-up visits have been deleted from the *CPT*. When billing critical care, remember the patient's condition must be of a critical nature, requiring the physician's bedside attendance to perform a service only he or she can perform.

Three hours of critical care (whether continuous or throughout the day) would be billed as follows:

99291—Critical care, first hour
99292 x 4—Each additional 30 minutes

This format applies to all visits of a critical (life-threatening) nature, even if the patient is not in a hospital critical care unit. All other visits (even when the patient *is* in the critical care unit) are billed using hospital visit codes.

These critical care codes are for global services, and all procedures performed to stabilize the patient are included in the service. However, other procedures—such as suturing a laceration; setting fractures; and reducing joint dislocations, lumbar punctures, and peritoneal lavage not directly related to critical care management—are reimbursed separately.

Another option for billing these services is to use the prolonged physician attendance codes: 99150, attendance for 30 minutes to one hour; and 99151, attendance for more than one hour. Since prolonged attendance is not billed as a global service, any procedures performed may be billed separately. When billing for prolonged attendance, bill only for the time spent in patient monitoring. Do not lump the time spent performing procedures into charges for prolonged attendance.

While this method of billing has been the Health Care Group's recommendation in the past, *a word of caution regarding use of prolonged attendance codes is necessary—no relative value units have been established for these codes, and no payment will be made by Medicare*. Private payors may continue to reimburse for these codes, but we expect the use of these codes to initiate much scrutiny.

Note: information in this column should not be interpreted as a substitute for legal or other expert advice. For a listing of Practice Management Consulting Network participants, call the Society's Department of Physician Services at 1-800-228-7823.

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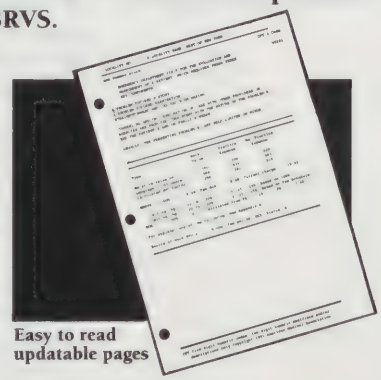
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Maria T. Montesano
Assistant Managing Editor

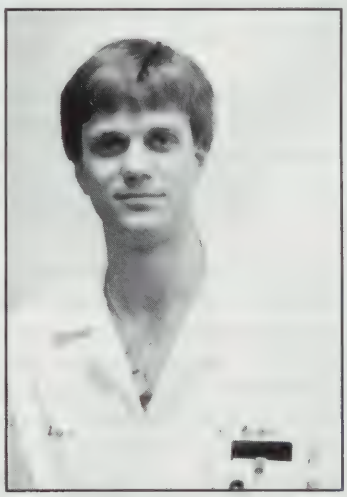
This final of three articles profiling the State Society's newly elected trustees features Daniel S. Henriksen, MD, Resident Physician Section, and Mark V. Caliendo, Student Section.

"I don't like to see legislative rules and solutions to medical education problems."
— Daniel Henriksen, MD

The future of medicine lies in the hands of residents and medical students throughout the world. Recognizing the immediate need to encourage residents and medical students to become involved in organized medicine early in their careers, the State Society within the last eight years has allotted two positions on the Board of Trustees to such future leaders.

The resident

Juggling resident work hours and the responsibilities of being a State Society trustee can be difficult. For Daniel S. Henriksen, MD, however, the support of his program advisors at York Hospital has allowed him time to do both.


Dr. Henriksen

Dr. Henriksen, the Society's new Resident Physician Section Trustee, was born in Philadelphia, but spent 15 years growing up in Colombia, South America. His mother was a nurse, and he credits her work and his own fascination with science as his incentive for becoming a doctor. He received his bachelor's degree from Eastern College in St. Davids and his medical degree from the Medical College of Pennsylvania. Dr. Henriksen is currently in his second year of residency in general surgery, which he chose as a specialty "because it caught my eye and my interest," he says. "I always wanted to do something that was general in nature, and I liked the hands-on of surgery."

His association with organized medicine did not come quite so naturally, but has grown with familiarity. He first glimpsed local organizations during his resident orientation in 1990: "We were exposed to the York County Medical Society and the Pennsylvania Medical Society, and the surgical residents were encouraged to join...I had never been involved in any kind of political, governmental, or organizational structure—not in college, not in medical school, not at all—until I came here."

He ran uncontested for the trustee position because he was one of the few residents remaining in state for several more years. His interest in the issues continues to grow as he realizes their effect on him as a physician. "The major issues now are how to change the medical system and how to pay for the medical care we know how to deliver."

Control of residency work hours is another issue on the top of his list. He says his own residency "has been monumental in opening my eyes to what 'resident work hours' really means." The AMA, struggling with this issue for almost five years, may now have a compromise in the works which Dr. Henriksen believes "is a step in the right direction." This year, while learning the broad scope of issues affecting American medicine, he will work for the Resident Physician Section on the resident work hours issue. "I don't like to see legislative rules and solutions to medical education problems," he says. "I'd like to see physicians make rules for their programs, and I'd like to communicate my own ideas."

Dr. Henriksen is interested in staying involved in organized medicine even after his two-year trustee term ends. He says he doesn't yet have "a complete grasp of how the Society works," but he is enjoying his experiences. "The trustee position is an opportunity for me more than anything," he says. "So far, I have benefited more

from my involvement in organized medicine than the Society has, but that will change...and I'm really looking forward to what I can give back."

The medical student

Several characteristics and experiences can lead people into medical professions. Mark V. Caliendo, the Society's newest student trustee, credits an acute childhood illness, human nature, and an interest in science for his decision.

Caliendo was just six years old when his appendix ruptured. He explains his experience as follows: "I was very young and scared at the time, and very uncertain about what was going to happen...when I got to the hospital, I layed there for three days, not knowing if I was going to live or die, not really understanding what illness and death were about. During that time, the doctors took me in, and it was just a matter of following human nature to look up to them and admire and respect what they were doing."

A native of Bucks County, Caliendo received his bachelor's degree from the University of North Carolina at Chapel Hill. He is a third-year medical student at Hahnemann University, where he was a member of the Medical Student Institute (MSI), Hahnemann's student government. As a trustee of the Society, he serves on the Publications Committee and the Council on Membership, and he is also a member of the Board of Directors of the Philadelphia County Medical Society and involved on a national level with the AMA's Student Section.



Mark Caliendo

When asked why he ran for the trustee position, Caliendo says, "I wanted to speak out, on behalf of medical students, to let the leaders in our profession know how changes that occur affect us." However, he says since becoming a trustee in October, he often sees his role as primarily learning from the Board and medicine's leaders, and bringing that information back to the students. "We're the ones who will have to work within the future medical system...and concerning the rapidly changing face of medicine, it's important to know where you came from to understand where you're going."

Caliendo credits Charles Bailey, MD, a Hahnemann graduate and a pioneer in open heart surgery, for teaching him "an important lesson about life." During a lecture at Hahnemann, Dr. Bailey spoke about his experience of working his way through college as a girdle saleman. Many years later, when thinking about how the heart valve works, he made an analogy between the mitral valve and the strings of a girdle. Caliendo says, "As it turns out, that was one of the ideas that led him to pioneer open heart, mitral valve surgery...he was very encouraging about being open to *all* of life's experiences, because they all contribute to your profession and how effective you are in your career."

As for issues affecting students, he says they are basically the same as those facing physicians; loss of autonomy tops his list: "Today's students want to be able to enjoy the same freedoms in practicing medicine as physicians traditionally have." Other important issues, according to Caliendo, are loan repayment schedules, resident work hours, and liability coverage. He says, "All these contribute to students' decisions regarding specialties, locations, and how well we're able to practice medicine in the managed-care environment of the next century. For future students, these are important because they have to decide *if* they want to go into medicine at all." And like other trustees in this series of profiles, Caliendo cautions against hurried reform to the nation's health care system. "Medicine is best handled by physicians," he adds, "and should not be left in the hands of insurance companies, lawyers, and 'big' government."

He is considering a specialty in neurosurgery or plastic and reconstructive surgery. As for his future involvement in organized medicine after his one-year term expires, Caliendo is not sure what will happen. He says he realizes great advantages to staying involved and hopes to do so: "It's hard to commit to anything with plans to do a surgical residency...but I think organized medicine is important, and I will make every effort to stay involved."

"I wanted to speak out, on behalf of medical students, to let the leaders in our profession know how changes that occur affect us."

— Mark Caliendo

SELECT MEDICAID FEES INCREASED

This month, Pennsylvania physicians should begin receiving increased Medical Assistance (MA) payments as a result of changes to the Medicaid fee schedule for selected maternity, pediatric, and primary care services. Increases will occur for services rendered on or after February 1, 1992.

Physician-specific increases include:

- office visit—from $18 to $20;
- initial office visit—from $18 to $30;
- vaginal delivery—from $312.50 to $800;
- C-section—from $459 to $800;
- EPSDT—from $25/$35 to $65; and
- emergency visit in emergency room—from $13 to $20-$50, depending on level of care provided.

The increases are a result of the release of $17.4 million of Medicaid monies by the governor. However, the remainder of the $50 million authorized by the state legislature to expand outpatient primary access to MA patients remains frozen.

State Society President Robert N. Moyers, MD, in a January letter to the governor, urged the release of the remaining $32.6 million, as well as $60 million for state mental hospitals still being held in reserve. Dr. Moyers' letter was sent on behalf of the Society, the Pennsylvania Academy of Family Physicians, the Psychiatric Physicians of Pennsylvania, and the Pennsylvania Section of the American College of Obstetricians and Gynecologists.

BLUE SHIELD DEVELOPS NEW RADIOLOGY PROGRAM

Pennsylvania Blue Shield has developed a new preferred provider program for outpatient elective radiology services. The Radiology Preferred Provider Program was approved by the state Department of Health (DOH) and Insurance Department on March 10, and May 1 is the target start-up date for Blue Shield's pilot program in the Allentown area. In contrast to Blue Shield's participating physician programs, not all radiologists will be permitted to participate. Blue Shield plans to limit participation to a select network of providers.

The program works as follows: if the subscriber receives covered services from a radiologist preferred provider, Blue Shield pays the full program allowance, and the radiologist is required to accept that amount as payment-in-full. However, if the subscriber opts to receive services from a non-preferred provider, the program allowance is reduced, and the subscriber must pay out of his or her own pocket the difference between the radiologist's charge and the reduced allowance.

The Society raised several concerns in comments submitted to the departments when the program was initially proposed. First, the Society questioned if the number of program participants in each area would be sufficient. The Insurance Department and DOH required Blue Shield to submit its list of proposed participants, and the departments have indicated that the number "will be sufficient."

Second, the Society expressed concern about Blue Shield's initially proposed 50 percent penalty to subscribers not utilizing preferred providers. Following the Society's comments, the penalty was dropped to 20 percent. According to an Insurance Department representative, a 20 percent reduction conforms to both departments' guidelines.

The state departments are concerned about adequate release of program information to physicians to help them make referrals consistent with patients' health care benefit programs. The departments have mandated a four-week lapse from the date of program approval to implementation. During that time, physicians will receive educational materials about the Radiology Preferred Provider Program. In the Allentown area, those materials were expected to be mailed on or soon after April 1.

One final note from the Society: although Blue Shield's Allentown program has been deemed a pilot program, no provisions exist to prevent Blue Shield from expanding the program throughout the Commonwealth at any time. However, the Insurance Department and DOH have assured the Society that they will closely monitor the effect of program implementation and use on subscribers. Any complaints about the program from subscribers, particularly related to access, may result in revocation of approval by the Insurance Department.

For additional information on this issue, call the State Society's Council on Medical Economics staff at 1-800-228-7823.

SOCIETY'S PROJECT PA ACTION PLAN APPROVED

Access to health care remains a problem nationwide. According to information from the Associated Press in Washington, DC, more than 35 million people in the United States are underserved by the nation's medical system. The State Society continues to address Pennsylvania's access problem through several programs, including Project Pennsylvania.

Approved and funded for implementation by the Society's Board of Trustees in September 1990, Project Pennsylvania is defined by the Society as "a centralized registry/referral source of health care practitioners willing to volunteer their services in caring for the medically indigent of Pennsylvania." The basic objectives of the program are to assess the access problem in Pennsylvania, establish a network of physicians and institutions to serve the medically indigent, and provide support as needed.

To date, the registry consists of approximately 60 physicians willing to volunteer health care services. Eleven are actively providing care through community health centers and programs sponsored by the state Department of Health, and the remainder will be placed in programs to be developed throughout the state.

During a February 5 meeting, the Society's Commission on Access to Health Care approved an action plan for Project Pennsylvania, which authorizes:

- publication of a project manual, produced by the State Society with the support of the Pennsylvania Osteopathic Medical Association and the Hospital Association of Pennsylvania;
- announcement of the availability of the project to the news media; and
- advertisement of the program to retired physicians to seek increased physician involvement.

For additional information about Project Pennsylvania, call the State Society's Department of Hospital Relations at 1-800-228-7823.

The New OSHA Regulations

The Health Care Group

Recently released regulations of the Occupational Safety and Health Administration (OSHA) require prompt attention by medical and dental practices.

OSHA's final regulations on occupational exposure to bloodborne pathogens, released in December 1991, mandate changes in practice equipment, routines, and recordkeeping to protect health care workers from contact with blood and other bodily fluids which may be infected with HIV or HBV. The central focus of the regulations, "universal precautions," requires health care workers to assume all blood and other bodily fluid is contaminated.

When do the requirements take effect?

The new regulations require practices to comply within a short timeframe: the first deadline is May 5, 1992. Written exposure control plans must be adopted for each location by that date in any practice with employees. This includes any incorporated practice, even if there are no nonphysician staff, since physicians are considered employees of the corporation. The written plan must cover a broad range of mandated exposure control efforts, from work routines to employee vaccinations to employee training records. Thus, practices must document their planned efforts even though actual implementation deadlines are later. Employee exposure control training and various record keeping requirements must be met by June 4, 1992; and final implementation—including required use of personal protective equipment, biohazard labeling, and HBV vaccination requirements—are mandated by July 6, 1992.

Who's affected?

All employers *must* comply if their employees (including physicians) *might* come into "occupational exposure"—reasonably anticipated skin, eye, mucous membrane, or parenteral contact with blood or other potentially infectious materials. The regulations do not apply to solo practices or partnerships which: 1) are unincorporated, and 2) have no nonphysician staff. However, every other physician's office must move quickly to adopt the required work and recordkeeping routines.

It is not enough for practices, like hospital-based groups, to simply piggyback on their hospitals' compliance actions. While those practices might adopt much of their hospitals' plans, the regulations are, in part, employer-specific enough that separate compliance is needed.

OSHA has a long history of tough enforcement, assessing arguably disproportionate fines for trivial violations of its requirements. Given the publicity about HIV and hepatitis B virus (HBV) infection, it's likely that OSHA will wage a tough (and well-publicized) campaign to assure that physicians' offices take the regulations seriously. And even without the threat of OSHA fines, the health risk to staff is serious enough that physicians will want to assure aggressive adoption and enforcement of required standards.

What's to be done?

Broadly, the regulations require physicians to:

1) Identify and document the potential risks of practice—in terms of staff positions which may involve exposure to infectious materials, as well as medical procedures requiring special precautions and waste materials requiring special handling;

2) Provide resources—handwashing facilities, personal protective equipment, appropriate waste disposal containers, and HBV vaccinations—to help staff members avoid contact with contaminated materials;

3) Adopt work routines to minimize the chances of infection;

4) Advise staff members of the office's "exposure control plan," train them in practice requirements, and label or color-code waste containers;

5) Establish recordkeeping routines to document staff training programs, HBV vaccination status, and steps taken if an

MARK YOUR DEADLINES:

May 5 - Written exposure control plan

June 4 - Employee training and record keeping in place

July 6 - HBV vaccination, biohazard labeling, protective equipment in use

The contributing authors, Geoffrey T. Anders, JD, CPBC, and Paul W. Smith, CPBC, are consultants with The Health Care Group, Plymouth Meeting.

employee is exposed to potential infection; and

6) Establish a committee to keep the exposure control plan current and to enforce its requirements.

The best way to proceed is to appoint an "OSHA Compliance Committee" immediately. Then set aside time at least weekly to begin tackling the requirements in a logical order. At the committee's first session, appoint one member to keep notes and compile them into the written exposure control plan. As assignments are given to each member, be sure to assign completion dates so nothing important gets put aside in the face of day-to-day practice demands.

Identifying risks

The regulations require identifying job classifications in which some or all employees may be exposed to infectious materials. The exposure control plan described above must document these job titles along with procedures and work tasks in which exposure may occur. In assessing these job classifications and tasks as having potential for exposure, physicians must assume that no personal protective equipment is in use and that all human blood, fluids, and other potentially infected materials are, in fact, infected.

Start to identify the affected job classifications by reviewing job descriptions. Then interview each and every staff member whether they might, even occasionally, come in contact with blood/fluids or sharps, equipment, or work surfaces which could be contaminated with blood or bodily fluids. Don't overlook the less-obvious incidents which may involve non-clinical staff. For example, if a patient should vomit in a reception area, the receptionist who cleans up would be exposed and thus must be listed. As an alternative, physicians could modify non-clinical personnel job descriptions to prohibit even occasional contact with potentially infectious fluids and materials.

Provide resources and develop routines

Detailed regulations require physicians to address work routines and mandate staff compliance. The theme of the routines developed should be "universal precautions:" in all circumstances blood, bodily fluids, and potentially contaminated materials or equipment are handled as if known to actually be infected. To comply with some of the requirements, a practice may need to order special equipment, labels, and containers.

First, *handwashing facilities* must be readily available. Where they are not, feasible antiseptic towelettes must be available and handwashing must be required as soon as possible. Physicians must absolutely require handwashing after contact with potentially infectious materials, as well as after gloves or other protective equipment are removed.

Second, except in rare circumstances, contaminated needles may not be bent, recapped, sheared, or broken. Pending decontamination, all reusable sharps must be placed in containers that are closable, puncture resistant, leakproof, labeled with a fluorescent orange biohazard symbol, and which do not require employees to reach into the container. Broken glass must not be picked up by hand, but instead cleaned up with brush and pan.

Specimens must be placed in containers meeting the same requirements as for reusable sharps to prevent leakage during collection, handling, processing, storage, and shipping. If the primary container is contaminated on the outside, or if there is a chance that the specimen could puncture the container, the primary container must be placed in a secondary container. Individual containers of blood or other specimens need not be individually labeled so long as they are placed in a properly labeled container during storage, transport, shipment, and/or disposal.

Third, for all procedures and tasks during which exposure may occur, physicians must give employees non-permeable personal protective equipment including, as appropriate, gloves, gowns, lab coats, face shields, mouthpieces, and ventilation devices. And they *must* use them. Any time they do not use the equipment, the physician will have to investigate and document the circumstances, with the goal of preventing future reoccurrences. The regulations require, too, that protective equipment be made available in appropriate sizes and cleaned, repaired, or replaced at no cost to the employee. Requiring use of protective equipment seems obvious. It's certainly reasonable to wear gloves when hand contact with blood/fluids or with contaminated equipment, laundry, or work surfaces may occur. Face shields protecting against spray or splashes of blood also make sense. And workers should wear gowns/hoods when gross contamination or other exposure may occur.

Fourth, physicians must also develop and follow a written schedule for cleaning/decontamination, and include it in the exposure control plan. Specifics will

depend on the surface/area to be cleaned, type of contamination likely, and the procedures performed in the area. Equipment, protective covers, and work surfaces must be disinfected *immediately* after completing a procedure or if an overt contamination (e.g., spilled blood) occurs. All reusable pails, cans, and similar receptacles must be inspected and decontaminated on a regularly scheduled basis; if visible contamination occurs, cleaning must occur as soon as possible.

Finally, contaminated laundry must be bagged in color-coded (fluorescent orange), labeled ("biohazard" with symbol) in containers which prevent leakage or soak-through. Laundry should not be sorted or rinsed on site. Staff handling laundry must use protective equipment, as in every other instance where exposure may occur.

Employee information and training

Each practice must provide training to all staff with any occupational exposure during working hours. Training must be provided before June 4, 1992, for current staff and immediately upon assignment to tasks with exposure risks for new employees or those undertaking new assignments. Training must recur for all employees with exposure risk within 12 months of the first training session. If the practice's routines change and expose employees to new or different risks, supplemental training must be provided at the time of change. Training sessions must meet minimum requirements, including providing staff with:

- A copy of the full OSHA regulations;
- A general explanation of the frequency, distribution, and symptoms of bloodborne diseases;
- An explanation of how bloodborne diseases are transmitted;
- An explanation of the practice's exposure control plan (and how to obtain a copy of the plan), including how to recognize activities that may involve exposure, and the benefits and limitations of the exposure control plan requirements that help prevent or reduce exposure;
- Information on the types, selection, proper use, location, handling, decontamination, and disposal of personal protective equipment;
- An explanation of the color-coding and labeling requirements;
- Information on HBV vaccinations, including efficiency, safety, administration, and availability from the practice free-of-charge; and
- An explanation of the procedures to be followed when an exposure incident occurs and in an emergency involving potentially infectious materials (including reporting requirements and the availability of evaluation and medical follow-up after the incident).

Obviously, training sessions must be interactive and conducted by a qualified individual who understands the exposure control plan. Most practices will find it desirable to develop a training manual, including the exposure control plan, to assure that all requirements are met and to save development of new training materials each time training must occur.

Vaccinations

Practices are required to make available, within 10 days of assignment (or by July 6, 1992, for current staff) and free-of-charge, the HBV vaccination series to all employees who have occupational exposure. Employees may decline vaccination by signing a statement that reads:

> *I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine at no charge to myself. However, I decline hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.*

If someone declines vaccination, but later changes his or her mind, the vaccination must be made available to them.

After an exposure incident

Following a report of possible exposure, practices must immediately offer a confidential medical evaluation and follow-up. The procedure involved includes:

1) Documenting the circumstances and "route of exposure";

2) Identifying and documenting the human source of the potentially infectious material, if permitted by state law:

3) Testing, after obtaining consent, the source's blood to determine if it is HIV/HBV infected, and informing the exposed staff member of the results (all subject to state laws);

4) Testing, after obtaining consent, the exposed employee's blood; and

5) Making available counseling, evaluation of reported illnesses, and post-exposure medical precautions, as recommended by the U.S. Public Health Service.

The physician conducting the post-exposure evaluation must be provided with a copy of OSHA's regulations, a description of the employee's duties, the circumstances of the incident, results of the blood testing, and any relevant medical records, including HBV vaccination status. Within 15 days after the evaluation, the practice must give the employee a copy of the written evaluation.

Recordkeeping

Two types of recordkeeping are required—a medical record and a training record. A medical record for each employee with occupational exposure must be kept until 30 years after termination of employment. The record should contain the staff member's name and social security number, HBV vaccination status, and any related medical records including dates of all vaccinations. All records related to any exposure incident must also be kept including results of examinations, testing, the written post-exposure evaluation, and copies of the information provided to the evaluating physician. As with any medical record, the files must be kept confidential and should not be disclosed to anyone (including other practice employees) without the individual's written consent.

Training records need to include the dates of sessions, training materials, name and qualifications of the individual performing the training, and employees (including job titles) who attended. These records must be kept for three years following the date of training. They must also be available for inspection and copying by an employee, as well as by OSHA representatives; and even if a practice is closing its doors permanently, OSHA must be provided three months advance notice prior to destroying the records.

What will it cost?

Compliance with the regulations will necessitate two types of costs—out-of-pocket expenses and allocation of personnel time. These are not necessarily all new costs to a practice if physicians have already been following some of the above routines to protect employees.

Estimates of cost prepared by the U.S. General Accounting office are expressed as "annual cost per physician in a practice," as follows:

Waste disposal/ warning labels	$ 74
Protective equipment	562
Housekeeping	59
Training	285
Vaccination	121
Records	23
Total	$1,124

Individual practice costs will vary widely depending on specialty and patient mix.

Time allocation includes such activities as development of your exposure control plan, preparation of training materials, conduct of training, and record keeping. Use of staff time may be materially reduced by purchase of prepared materials on exposure control plans and employee training.

Complying with OSHA's regulations will be time-consuming and burdensome. Nonetheless, the requirements make good sense. Get behind the effort to develop the required routines and records to give practice personnel the best protection possible.

OSHA PUBLICATION ORDER FORM

(Photocopy this form to preserve the article on the reverse side)

The Pennsylvania Medical Society is offering an OSHA Information Kit, which includes all the necessary documentation to comply with the regulations, as an exclusive benefit of membership. The kit includes:

- OSHA Final Regulation Overview
- Model Exposure Control Plan
- Employee Training Manual
- Copy of Part 1910.1030, Title 29 Code of Federal OSHA Regulations

ORDERING INFORMATION: This OSHA Information Kit is available to members only for $10 per kit. For fastest delivery, mail a copy of this order form and payment to: Pennsylvania Medical Society, Department of Physician Services, 777 East Park Drive, Harrisburg, PA 17105-8820, 1-800-228-7823.

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Who Reviews the Reviewers?

Donald E. Harrop, MD

The preparation for performance assessments is a stressful experience for peer review organization (PRO) staff. So much depends upon achieving a good report from the Health Care Financing Administration (HCFA), and poor performance can jeopardize a PRO's federal contract for Medicare review. This year brought added stress because both assessments—SuperPRO and PROMPTS—occurred at approximately the same time.

There are several times during each peer review organization (PRO) contract period when Keystone Peer Review Organization (KePRO) staff personnel and physicians feel special empathy for physicians and providers subject to KePRO review. These are the times when the PRO is second-guessed by the Health Care Financing Administration (HCFA) through SuperPRO and PROMPTS (Peer Review Organization Monitoring Protocal and Tracking System) evaluations.

The SuperPRO assessment appears simple on the surface, especially at the start, when KePRO boxes up and sends to SuperPRO previously reviewed medical records. The assessment, however, is a little more involved than that. Between 200 and 300 specific records are selected by SuperPRO from random samples taken from all cases reviewed during a certain period of time. Additionally, some cases were approved on site at hospitals, which means KePRO must request the records from the hospitals.

After being submitted, the records are reviewed by SuperPRO, which agrees or disagrees with KePRO's review decisions. KePRO must then re-review the records involving disagreement and defend the rationale for decisions made. The process takes a lot of work, and just as physicians and providers often become aggravated with KePRO's decisions, KePRO also becomes irritated with select SuperPRO disagreements. When the process is finalized, disagreement percentages are tabulated and become one of the considerations used by HCFA to determine if a PRO's contract will be renewed without competition.

The PROMPTS review is much different and involves on-site evaluation at KePRO's office by representatives from the HCFA regional office. During this compliance audit, HCFA looks at all processes and procedures to assure KePRO is doing what is outlined in its technical contract proposal and exactly as outlined. The PROMPTS review involves everything from community outreach to the review process, again including review decisions.

PROMPTS is the most important evaluation for a PRO, since a poor score will trigger a competitive contract situation. The review is usually very stressful on a PRO's staff, not only because of the importance of the work involved, but also because of on-site visits by HCFA. For several weeks, between the preparation for the evaluation and the on-site visits, people are taken away from their routine duties—which they must still accomplish within specified timeframes—to help with the PROMPTS review.

Ordinarily, it takes several months before the PROMPTS evaluation is completed, and a report is compiled and sent to the PRO. KePRO has, however, already received the SuperPRO results and was pleased with them. Although comparisons are very difficult to make because of differing PRO funding cycles, KePRO had fewer disagreements than the national averages in many categories and compared favorably in all categories.

Donald E. Harrop, MD, is president of the Keystone Peer Review Organization.

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Wednesday, May 6, 1992

Aggressive Cardiac Procedures: Catheter Intervention or Coronary Bypass Surgery

Moderator: William J. Untereker, MD

3:00-3:30	Balloon and laser angioplasty, stents, atherectomy: For whom, why, complications, short and long-term results	*Alexander Stratienko, MD*
3:30-4:00	Coronary surgery for the geriatric patient: What are the risks and the results?	*James D. Sink, MD*
4:00-5:00	Case Presentations	*Bradford Lin, MD*
	Panel Discussion	*Michael Adesman, MD* *William J. Untereker, MD* *Frederic J. Weber, MD*

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NEW STRATEGY FOR ELIMINATING TRANSMISSION OF HEPATITIS B

Hepatitis B virus (HBV) causes an estimated 200,000 to 300,000 new infections annually in the U.S. Of these, approximately 10 percent will become chronic carriers of HBV, and a good proportion of the infections will progress to chronic liver disease and hepatic cancer. Consequently, approximately 4,000 to 5,000 persons in the U.S. die every year as a result of the late effects of chronic HBV infection.

Previous preventive efforts

Previous preventive efforts have been unsuccessful in significantly reducing hepatitis B incidence in the U.S. The best prevention against this disease is immunization with hepatitis B vaccine, which has been available for several years. Until now, the focus has been on vaccinating individuals at high risk for the infection, including IV drug users, male homosexuals, heterosexuals with multiple sexual contacts, and individuals who are occupationally exposed to blood or other body fluids.

This strategy has met with limited success, not because of lack of vaccine effectiveness (the vaccine is 80-95 percent effective), but because most people at high risk have not been vaccinated. This is due to lack of awareness and/or motivation among health care professionals and high-risk populations.

Rationale for universal childhood immunization

Largely because of the failure of current strategy, the Centers for Disease Control is now recommending universal immunization of infants. Since there is no reliable treatment to eradicate hepatitis B infection, and because several years of effort to publicize the need for those at high risk to utilize the vaccine have been unsuccessful, universal immunization of infants appears to be the only way to make a significant impact.

This strategy has been successful in reducing by 99 percent or greater incidence of several other previously common diseases, including poliomyelitis, diphtheria, pertussis, tetanus, measles, mumps, and rubella. The cost of vaccinating infants is far less than that of older children and adults, and clinic visits can be worked into routine pediatric health care visits. Also approximately one-third of new HBV cases in the U.S. do not occur in people at high risk and would therefore be missed by any strategy which only targets high-risk groups.

Schedule and dose

Three- or four-dose schedules may be used, although there is no evidence that the four-dose schedule provides any better protection. Because exact age of vaccination is not crucial, it may be worked in with other clinic visits.

The first dose may be given at birth or at the first immunization visit at two months, or sometime in between. The next dose must be given at least one month later, but two months may be more convenient and is perfectly acceptable. The third dose, which is a booster, is most effective if given at least five months following the second dose. It may, however, be given as soon as two months following the second dose. HBV vaccines do not interfere with other childhood vaccines, so they may be given during the same clinic visits.

Other considerations

Previous recommendations for prevention of hepatitis B remain in effect, including immunization of high-risk groups, universal screening of pregnant women, and post-exposure prophylaxis of exposed individuals. Newborns of women who test positive for hepatitis B surface antigen (HBsAg) should have more intensive prophylaxis, including the use of hepatitis B immune gobulin within 12 hours of birth and a series of hepatits B vaccines according to the schedule above.

Testing for hepatitis B surface antibody (HBsAb) is sometimes performed prior to immunizing adults because a positive test precludes the need for immunization. However, such a procedure is not useful for infants or children because of the very low rate of positivity. Nor is there any need for post-vaccination testing for antibody response to the vaccine, except in instances where a less-than-satisfactory response to the vaccine is anticipated.

Dale Tavris, MD, MPH
Pennsylvania Department of Health

IMPLEMENTING OSHA REGS ON BLOODBORNE DISEASES

Effective Dates

The U.S. Department of Labor, Occupational Safety and Health Administration (OSHA) regulations regarding infection control in the health care setting passed into law January 6, 1992, and became effective March 6. The new law requires all employers whose employees have occupational exposure to "blood or other potentially infectious materials" to:

- have in place a written exposure control plan by May 5, 1992;
- provide employees with comprehensive infection control training during work hours by June 4, 1992;
- have information and recordkeeping systems in place by June 4, 1992;
- have engineering, work practice controls, and housekeeping procedures in place by July 6, 1992;
- have employees vaccinated against hepatitis by July 6, 1992;
- have post-exposure programs in place by July 6, 1992; and
- have labels and sign systems activated by July 6, 1992.

For more detailed information about the plans and programs required by the regulations, see the February 1992 issue of PENNSYLVANIA MEDICINE (pages 38-39).

Also, the State Society is offering a program in April designed to help physicians meet the OSHA requirements. Dates and locations include: April 21—King of Prussia, April 22—Harrisburg, and April 23—Pittsburgh. For additional information, call the Society's Department of Physician Services at 1-800-228-7823. The AMA has also prepared a package of materials to help physicians with implementation. For a copy, call 1-800-AMA-3211.

Smaller businesses with especially hazardous operations may seek further help in meeting requirements through the OSHA Consultation Program. The free consultation service, funded largely by OSHA, is offered by Indiana University of Pennsylvania (IUP) and provides professional advice and help in maintaining continued, effective worker protection. Currently, the waiting period for the confidential service is four to nine months, but further information is available by calling (412) 357-2561 or 1-800-382-1241.

HU

Hahnemann University

Department of Medicine Grand Rounds
Wednesdays 8:30 a.m.-9:30 a.m.
April—May 1992

April 1992

April 1, 1992

CURRENT CONTRACEPTIVE MANAGEMENT: BENEFITS AND RISKS
Richard A. Baker, MD
Professor and Vice Chairman
Department of Obstetrics and Gynecology
Hahnemann University

April 8, 1992

PRINCIPLES GOVERNING THE USE OF THROMBOLYTIC AGENTS
Burton E. Sobel, MD
Lewin Professor of Medicine
Director, Cardiovascular Division
Washington University School of Medicine
St. Louis, MO

April 15, 1992

INTRAVASCULAR CATHETER-RELATED INFECTIONS
Dennis G. Macki, MD
Professor of Medicine
Chief, Section of Infectious Diseases
University of Wisconsin Medical School
Madison, WI

April 22, 1992

NUTRITIONAL SUPPORT IN THE CRITICAL CARE UNIT
Rosemarie L. Fisher, MD
Associate Professor of Medicine
Division of Digestive Diseases
Department of Internal Medicine
Yale University School of Medicine
New Haven, CT

ENDOSCOPIC MANAGEMENT OF BILIARY TRACT DISORDERS
Jerome H. Siegel, MD
Associate Professor of Medicine
Mt. Sinai School of Medicine
Chief, Endoscopy Unit
Beth Israel Medical Center North
New York, NY

April 29, 1992

DEVELOPMENT OF SKIN SUBSTITUTES
Richard L. Spielvogel, MD
Professor of Medicine and Dermatology
Director, Division of Dermatology
Hahnemann University

May 1992

May 6, 1992

HYPERTENSION IN PREGNANCY
Robert W. Schrier, MD
Professor and Chairman
Department of Medicine
University of Colorado School of Medicine
Denver, CO

May 13, 1992

INVASIVE VERSUS NONINVASIVE
ASSESSMENT OF VALVULAR HEART DISEASE
Richard Gorlin, MD
Professor and Chairman
Department of Medicine
Mt. Sinai School of Medicine
New York, NY

May 20, 1992

PARANEOPLASTIC ENDOCRINE SYNDROMES
Kenneth L. Becker, MD, PhD
Professor of Medicine and Physiology
Director, Division of Endocrinology
George Washington University Medical Center
and VA Medical Center
Washington, DC

May 27, 1992

GUILLAIN-BARRE-STROLLE SYNDROME
Michael Sherman, MD
Assistant Professor of Medicine
Director, Pulmonary Function Laboratory
Division of Allergy, Critical Care
& Pulmonary Medicine
Hahnemann University

Seth Tarras, MD
Assistant Professor of Neurology
Director, EMG Laboratory
Director, ALS Center
Department of Neurology
Hahnemann University

Scott Hessen, MD
Assistant Professor of Medicine
Clinical Electrophysiology Laboratory
Likoff Cardiovascular Institute
Hahnemann University

Hahnemann University Department of Medicine Wednesday Medical Seminar Series
8:30 AM-3:30 PM

April 22, 1992
UPDATE IN GASTROENTEROLOGY, NUTRITION, AND ENDOSCOPY

May 5-6, 1992
HYPERTENSION & KIDNEY DISEASE

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As an organization accredited by the Accreditation Council for Continuing Medical Education (ACCME), Hahnemann University designates this continuing medical education activity as Category 1 of the Physician's Recognition Award of the American Medical Association. One credit hour may be claimed for each hour of participation by the individual physician.

For information call the Office of Continuing Education (215) 448-8263

SOCIETY CO-SPONSORS AIDS PROGRAM FOR EDUCATORS

One out of every 100 cases of reported AIDS has been among teenagers, according to information from the Pittsburgh AIDS Center for Treatment at Presbyterian University Hospital. Recognizing a need for education at the secondary school level, the State Society, along with the state Department of Education and Penn State Harrisburg, sponsored a program for educators and administrators on AIDS education, February 25 at Penn State Harrisburg in Middletown.

John J. Dennehy, MD, a member of the medical staff at Geisinger Medical Center and chairman of the State Society's Commission on Public Health, opened the three-hour program, "HIV Disease/AIDS Education for Secondary Teachers, Administrators, and School Nurses," with an update on the infection and the disease. He discussed the epidemiology of AIDS in Pennsylvania, the nature of the disease, common misconceptions, and infection control policies and procedures. His series of slides included many interesting statistics and publication excerpts, including the first indication of the AIDS virus in a 1981 issue of "Morbidity and Mortality Weekly Report," published by the Centers for Disease Control in Atlanta, Georgia.

Marian Sutter, PhD, certified health education specialist from the Pennsylvania Department of Health, then offered a two-part presentation. In the first part, she discussed Pennsylvania-specific data related to the prevalance and distribution of the disease. She also talked about risk behaviors among Pennsylvania high school students. In the second part, Dr. Sutter tackled how to help students deal with the "it can't happen to me attitude" and how to teach prevention behaviors. Attendees participated in an exercise called "Shake and Sign."

Each participant received a folded piece of paper with lines for four signatures and was asked to walk around the room, shake hands with four people, and have them sign the paper. Then, participants opened their papers to find one of three symbols: a sunburst, symbolizing they had "used protection" when shaking hands; a star, symbolizing "no protection was used"; and a lightening bolt, symbolizing infection with the "z virus."

Attendees with lightening bolts were asked to stand, and anyone who had contact with them and did not use protection stood, and anyone who had contact with those standing and did not use protection stood, etc.

Participants discussed the similarities between the "z virus" and HIV. The exercise, recommended for grades eight and above, demonstrated the "pyramid of infection"—how the infection spreads. Additional classroom exercises were provided in a Department of Education resource guide.

Sam Monismith, DEd, a health education professor at Penn State Harrisburg, also dealt with the "it can't happen to me" attitude and presented a video targeting teen audiences. Extensive question-and-answer periods were included throughout the program, and several other educational handouts and guides were given to attendees.

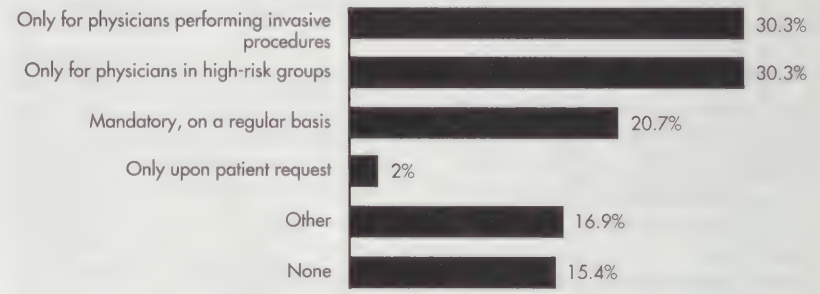
Approximately 100 educators attended from throughout the Commonwealth, including 12 from the Pittsburgh area and eight from State College. Evaluations were positive, and the State Society and Penn State Harrisburg surveyed participants to learn about other public health issues of interest for future program topics.



Educators participate in "Shake and Sign" during an AIDS program co-sponsored by the State Society, Penn State Harrisburg, and the state Department of Health.

STATS

When asked, "What type of HIV testing should there be for physicians?," the membership/leadership of the Pennsylvania Medical Society responded:



Source: Pennsylvania Medical Society 1991 Membership/Leadership Poll conducted by the Society's Educational and Scientific Trust

HAZARDOUS WASTE FORUM ADDRESSES CONCERNS

Physicians, legislators, legislative aides, and other concerned citizens attended a Society-hosted forum on March 4 to learn more about safely disposing hazardous waste without jeopardizing public health. Robert N. Moyers, MD, State Society president, offered introductory remarks, and David L. Hawk, MD, MPH, director of the York Bureau of Health, moderated the half-day program.

Several staff members from the state Department of Environmental Resources (DER) participated as part of the forum panel: Karl Shaeffer, hazardous waste siting team coordinator, discussed criteria used in determining hazardous waste landfill and incineration sites; James M. Salvaggio, special assistant of air and waste management, explained air quality permits and operating conditions at the sites; and Barbara L. Harper, PhD, public health toxicologist and chief of advanced science and research, explained DER's risk assessment guidelines for hazardous waste.



George Lumb, MD, a scholar in residence at Duke University, presented his views on the "difficult disposal" of hazardous waste incineration during the Society's recent forum.

George Lumb, MD, a scholar in residence in the Integrated Toxicology Program of the Pathology Department of Duke University, then presented his views on the "easy decisions, difficult implementation" of hazardous waste disposal. George C. Miller II, MD, a private practice obstetrics and gynecology specialist from Lewisburg, wrapped up the program with a special presentation of his research on the possible health risks of hazardous waste disposal and incineration.

COUNTY NEWS

BCMS SEMINARS TACKLE PHYSICIAN ISSUES

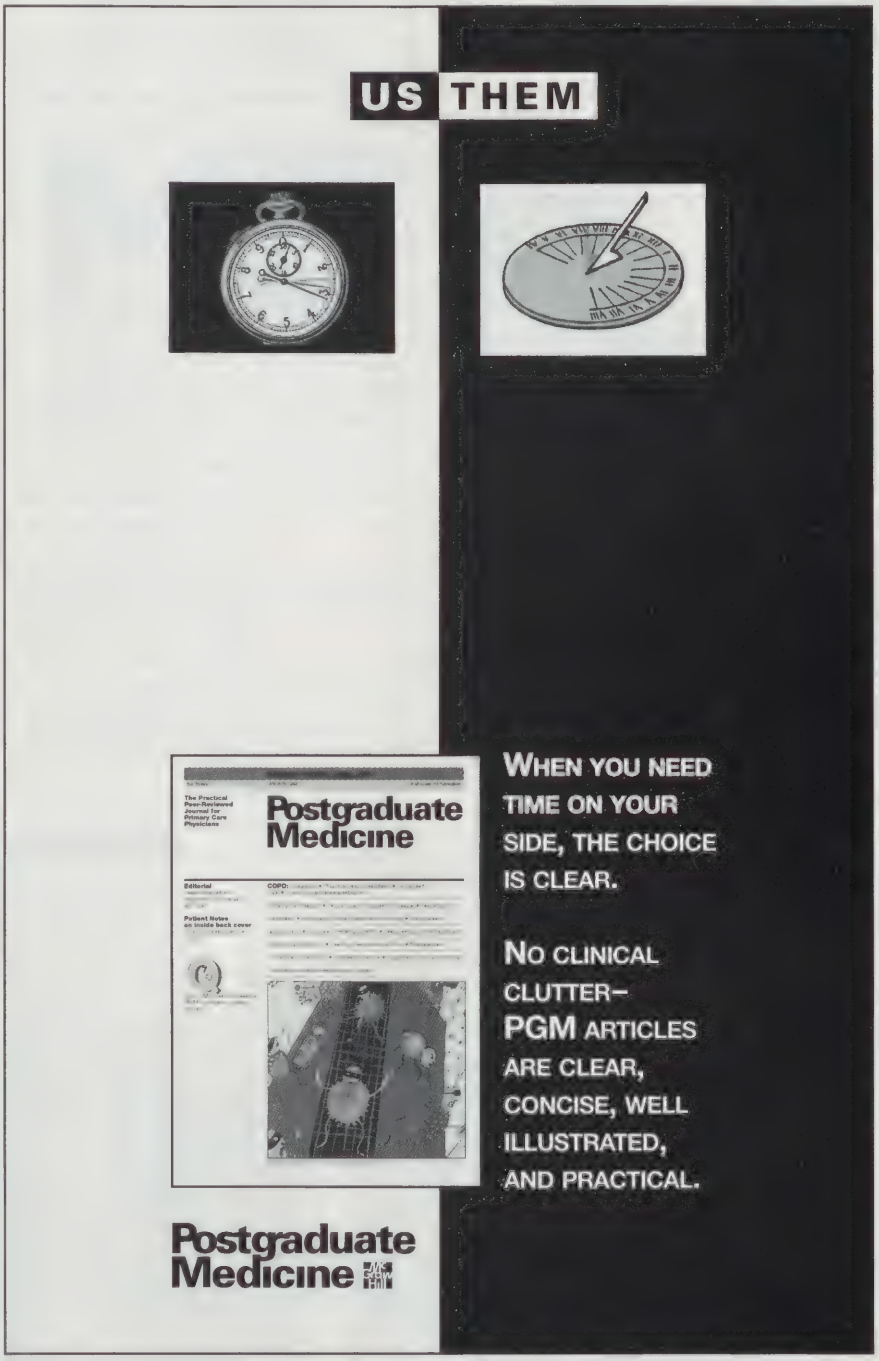
The Beaver County Medical Society (BCMS) held a series of three seminars in February and March tackling current issues affecting physicians and their office staff, including CPT coding, risk management, and Medical Assistance (MA) claims.

A February 10 seminar, "CPT Coding/Medicare Reimbursement for Office Personnel," presented by Josette P. Derricks, health care reimbursement consultant, drew 96 attendees. Codes discussed related to office/outpatient services, hospital/inpatient services, consultations, critical care, and modifiers and descriptors.

"Risk Management for Physicians and Office Managers," held on February 13 and presented by Jane L. Conley, vice president of risk management for the Pennsylvania Medical Society Liability Insurance Company (PMSLIC), drew 76 attendees and a number of positive evaluations. The one-hour program outlined the medical-legal ramifications of the activities of physician office personnel, and the importance of physician-patient and staff-patient relationships in patient satisfaction and malpractice litigation prevention.

The third program in the series, "Medical Assistance Claims Seminar," held on March 25, featured Richard L. Henry, MA program specialist for the state Department of Public Welfare (DPW). He presented the basics of MA claims and how to avoid claims rejections. The seminar was BCMS's first step in implementing a Medicaid Ombudsman Program to provide assistance to members with claims concerns. The program is a cooperative effort between the State Society, BCMS, and DPW.

Among other activities, the county society sponsored a presentation by Edward J. Kabala, Esq., on



"Protecting Your Assets in a Liability Suit." BCMS is also co-sponsoring, with the Medical Center in Beaver, a grand rounds lecture on April 10, 1992, from 8:00-9:00 a.m. Jeff Greenawalt, the State Society's director of educational and scientific affairs, will speak. For additional information about the lecture or other BCMS activities, call (412) 775-7027.

SPECIALTY SOCIETY NEWS

ACADEMY SPONSORING ANNUAL MEETING IN MAY

The Pennsylvania Academy of Physical Medicine and Rehabilitation will sponsor its annual meeting on May 2, 1992, at the Sheraton Hotel at Station Square in Pittsburgh. State Senator Melissa Hart (R-Allegheny) will present the keynote lecture on the impact of recent legislation on the practice of medicine.

A panel discussion about psychiatric issues will also be featured, and panelists will include Donald McCoy, director of regulatory affairs and specialty legislation for the Pennsylvania Medical Society; Joseph Ricci, MD, vice president of medical affairs for Pennsylvania Blue Shield; and Francis Bonner, lobbyist for the Pennsylvania Academy.

For additional information, call the Academy at (215) 278-8460.

SPECIALTY SOCIETY NEWS

OTOLARYNGOLOGISTS TO MEET IN HERSHEY

The Pennsylvania Academy of Otolaryngology-Head and Neck Surgery (PAO-HNS) will hold its annual meeting June 18-20, 1992, at the Hotel Hershey. The program will include the presentation of scientific papers, symposia, and special lectures on topics of interest to physicians, nurses, and technicians.

Fred Owens, MD, neuro-otologist at Baylor University Medical Center in Dallas, Texas, will keynote the meeting, speaking on cochlear implants and presenting the closing session. Other program topics include: The Role of Radical Mastoidectomy in Contemporary Otologic Surgery, Nasal Pharyngeal Malignancies in Children, and DNA Flow Cytometry in Acoustic Neuromas.

PAO-HNS is accredited by the State Society to sponsor continuing medical education for physicians. For additional information,call Al Walter at (215) 375-4311.

AMA CALLS FOR PAPERS ON PHYSICIAN HEALTH

The 1993 International Conference on Physician Health—co-sponsored by the AMA, the Federation of State Medical Boards, the Canadian Medical Association, and the Federation of Medical Licensing Authorities of Canada—is scheduled January 28-31, 1993, in Scottsdale, Arizona. The conference will provide a forum for practitioners and researchers to present recent findings and innovative treatment and educational programs in the area of physician health.

A range of issues relative to physicians will be addressed during the conference, including AIDS, the HIV-positive physician, problems related to aging, health promotion among physicians, mental illness, physical disability, and substanse abuse among physicians. Possible topics for presentation—through poster sessions, paper sessions, and workshops—include: incidence of health problems among physicians, the presentation of health problems by physicians, the impact of disorders on physicians' families and practices, the medical-legal implications of various disorders, and the impact of disorders on hospital administrators. Abstracts which address related topics are also welcome.

Submissions must be received by the AMA by June 15, 1992. For further information, call Patrick W. McGuffin, PhD, at (312) 464-4064.

OB-GYN UPDATE
FOR THE FAMILY PRACTITIONER

Saturday, May 9, 1992
8:30 a.m. - 5:00 p.m.

West Wing Auditorium, Shadyside Hospital, Pittsburgh, PA

PROGRAM DIRECTORS

AMIR H. ANSARI, M.D.
Chairman, Department of Obstetrics and Gynecology,
Shadyside Hospital
Director, Pittsburgh Institute of Reproductive Medicine,
Pittsburgh, Pennsylvania

ERIC S. MILLER, M.D.
Director, Family Practice Residency, OB/GYN Program,
Shadyside Hospital, Pittsburgh, PA

PRESENTED BY SHADYSIDE HOSPITAL

Departments of Obstetrics and Gynecology,
Family & Community Medicine
and Office of Continuing Medical Education

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PRELIMINARY CALL TO THE 1992 ANNUAL MEETING HOUSE OF DELEGATES

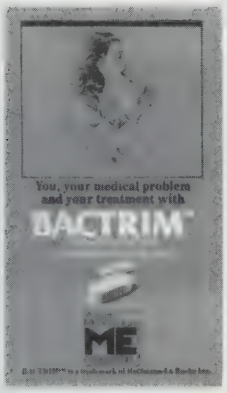
The House of Delegates of the Pennsylvania Medical Society will convene its annual meeting at the Adam's Mark Hotel, Philadelphia, Pennsylvania, on Friday, October 23, 1992. The second session will convene Saturday, October 24, 1992, and the third session Sunday, October 25, 1992. Details regarding the starting times of all three sessions will appear in the Official Call in the August 1992 issue of PENNSYLVANIA MEDICINE.

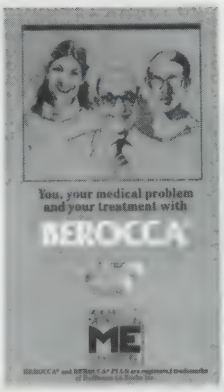
All proposed amendments to the Bylaws must be submitted to the office of the Secretary of this Society on or before June 23, 1992. Such amendments may be proposed upon the written petition of 15 active or associate members of the Society, or by the Committee on Bylaws. Resolutions to be considered by the House may be submitted in writing to the Secretary by a delegate acting in his/her own behalf or for the component medical society or specialty society he/she represents. If received prior to September 23, 1992, resolutions will be published in the *Official Reports Book*.

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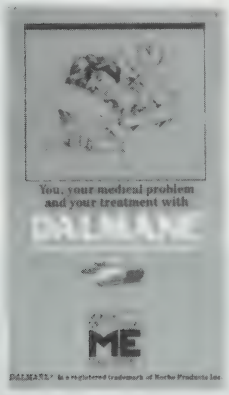


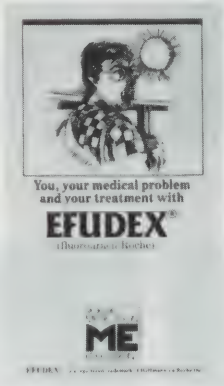
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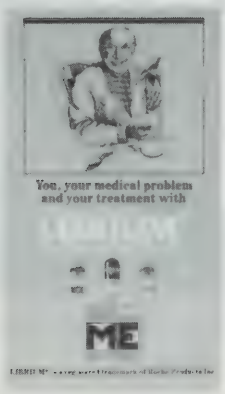
Each booklet helps you provide...

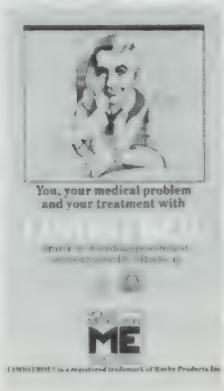
- Reinforcement of your instructions
- Enhancement of compliance
- Satisfaction with office visits

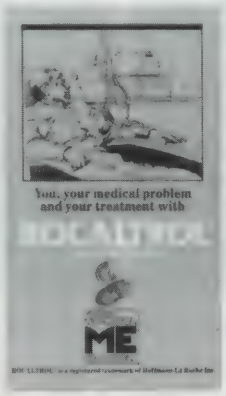
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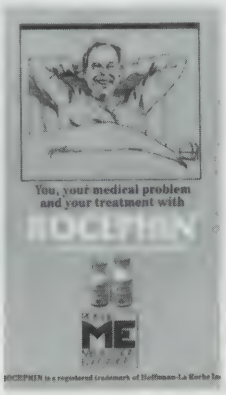


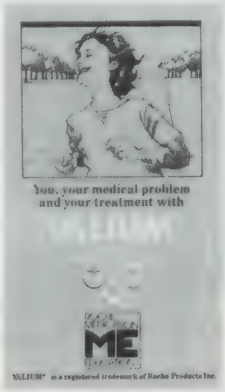












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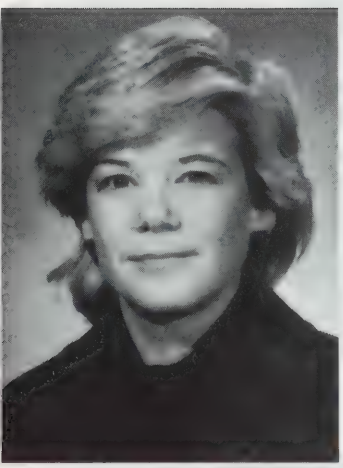
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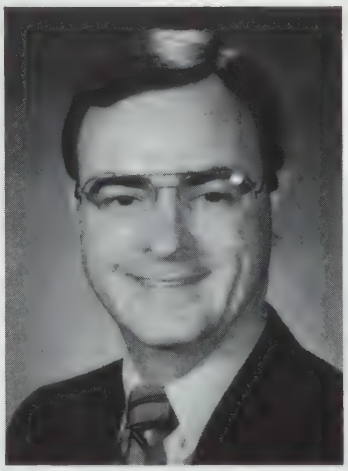
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Michael Weiss

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Wednesday, April 1, 1992

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Danville Days Inn

2nd Annual Focus on Sports Medicine
Saturday, April 11, 1992
Danville Days Inn

Airway Diseases
Wednesday, April 29, 1992

6th Annual Sight Loss Support Group Meeting
Wednesday, May 6, 1992
Danville Days Inn

Care of the Diabetic with the Dysvascular Foot
Wednesday, May 20, 1992

6th Annual Symposium in Clinical Medicine
June 22-25, 1992
Hilton Head Island, SC

Please check each specific flyer as it arrives for starting time, location, number of credit hours, and types of credit. Programs may be cancelled due to insufficient registration. If not pre-registered, please call to confirm the program.

Geisinger

As an organization accredited by the Pennsylvania Medical Society for its continuing medical education program, the Geisinger Clinic designates these activities as meeting the criteria for Category I credit for the American Medical Association's Physician's Recognition Award and the Pennsylvania Medical Society membership requirement. Please refer to each individual program flyer for registration fees, starting times, and number of credit hours. For further information or for copies of individual programs, call Sharon Hanley, RMP, collect, at 717-271-6692. There is a 24-hour answering service available. You may also write to her at North Academy Avenue, Danville, PA 17822-1350.

June 13, 1992
12th ANNUAL
ADVANCES IN
GASTROENTEROLOGY

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1. Data on file, Lilly Research Laboratories. *See accompanying page for prescribing information.* ©1991, ELI LILLY AND COMPANY NZ-2947-B-249304

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Contraindication: Known hypersensitivity to the drug. Because cross sensitivity in this class of compounds has been observed, H_2-receptor antagonists, including Axid, should not be administered to patients with a history of hypersensitivity to other H_2-receptor antagonists.

Precautions: *General*–1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests–False-positive tests for urobilinogen with Multistix® may occur during therapy.

Drug Interactions–No interactions have been observed with theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility–A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups.The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy–Teratogenic Effects–Pregnancy Category C–Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers–Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use–Safety and effectiveness in children have not been established.

Use in Elderly Patients–Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Worldwide, controlled clinical trials included over 6,000 patients given nizatidine in studies of varying durations. Placebo-controlled trials in the United States and Canada included over 2,600 patients given nizatidine and over 1,700 given placebo. Among the adverse events in these placebo-controlled trials, only anemia (0.2% vs 0%) and urticaria (0.5% vs 0.1%) were significantly more common in the nizatidine group. Of the adverse events that occurred at a frequency of 1% or more, there was no statistically significant difference between Axid and placebo in the incidence of any of these events (see package insert for complete information).

A variety of less common events were also reported; it was not possible to determine whether these were caused by nizatidine.

Hepatic–Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

Cardiovascular–In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

CNS–Rare cases of reversible mental confusion have been reported.

Endocrine–Clinical pharmacology studies and controlled clinical trials showed no evidence of anti-androgenic activity due to nizatidine. Impotence and decreased libido were reported with similar frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic–Anemia was reported significantly more frequently in nizatidine than in placebo-treated patients. Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H_2-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental–Urticaria was reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity–As with other H_2-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other–Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. The ability of hemodialysis to remove nizatidine from the body has not been conclusively demonstrated; however, due to its large volume of distribution, nizatidine is not expected to be efficiently removed from the body by this method.

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INCIDENCE OF CIGARETTE SMOKING AND SMOKELESS TOBACCO USE AMONG MIDDLE SCHOOL STUDENTS IN A PENNSYLVANIA COUNTY

Dean Hess, MEd, RRT; Barbara Swindler, BS, RRT; Mark Simmons, RRT; David Wilson, MEd; Lisa Marriott, BS; Krista Clark, RRT

OBJECTIVE: The use of tobacco among adolescents remains a concern internationally. This study was conducted to determine the rate of cigarette smoking and smokeless tobacco use among middle school students in one Pennsylvania county.

METHODS: Middle school students from one urban, one suburban, and one rural school completed a confidential survey about their attitudes and use of tobacco. Results were tabulated according to demographics, and conclusions were drawn.

RESULTS: Smoking was more prevalent among females than among males, and the percentage of smokers increased with grade level. There were significant differences between the percentages of smokers at the three schools, with the highest percentage in the suburban setting. Responses indicated that smoking by a student was significantly more prevalent when one or both of the parents smoked than when neither parent smoked. There were no significant differences between the percentages of tobacco usage by races, except in the case of smokeless tobacco, which was used mostly by white males.

CONCLUSION: Because a significant number of students smoke by the time they reach middle school, smoking prevention programs should begin at the elementary school level.

For additional information or a copy of the complete study, contact Dean Hess at the York Hospital Department of Research, (717) 771-2223.

THE USE OF DUAL THERAPY TO TREAT GONORRHEA AND CHLAMYDIA INFECTIONS

David H. Much, PhD; Johnson W. Martin, PhD

OBJECTIVE: Many local health departments find it increasingly difficult to keep up with the cost of locating, screening, and treating the increasing number of chlamydial cases, especially the majority of cases that are asymptomatic and/or co-infected with gonorrhea. This study was conducted to determine the effectiveness of treating all positive gonorrhea patients with two antibiotics in order to decrease the prevalence of chlamydia, as well as gonorrhea infections.

METHODS: Three health departments contributed data on the prevalence of gonorrhea and chlamydia during a five-year period. Single therapy regimen consisted of either ceftriaxone or ciprofloxacin to treat gonorrhea and doxycycline to treat chlamydia. Dual therapy consisted of the administration of both antibiotics to patients positive for gonorrhea. Two of the three health departments instituted dual therapy, and the third treated the two infections separately.

RESULTS: The number of patients positive for gonorrhea, chlamydia, or co-infected with both bacteria, decreased over a five-year period from 1985 to 1990 when dual therapy was used to treat positive gonorrhea patients, but increased when a single therapy regimen was employed.

CONCLUSION: The results suggest that dual therapy alone may have contributed to a significant reduction in diagnosed chlamydia, as well as gonorrhea cases. A control effort combining screening, contact notification and referral, and dual therapy might result in even greater reduction in chlamydia morbidity.

For additional information or a copy of the complete study, contact David Much, PhD, at the Muhlenberg College Biology Department, (215) 821-3256.

THE INTOXICATED DRIVER: SCOPE OF THE PROBLEM AND ITS LEGAL CONSEQUENCES

Steve Pandelidis, MD; Nikhileshwer Agarwal, MD; Katherine Pandelidis, BA

OBJECTIVE: This study was undertaken at York Hospital to analyze the problem of driving under the influence of alcohol among patients admitted to the hospital following a motor vehicle accident.

METHODS: Through cooperation with the York County District Attorney's office, the legal fate of those drivers with laboratory evidence of intoxication was examined. An analysis was undertaken to determine whether or not the time of the accident or the driver's injuries affected the frequency of legal prosecution.

RESULTS: In 1988, 240 drivers required admission to the trauma service. Among those drivers undergoing blood alcohol determination, 35 percent were legally intoxicated (ETOH 100 mg/dl). Sixty-one percent of the legally intoxicated drivers were either convicted of driving under the influence or placed in the Accelerated Rehabilitative Disposition Program.

CONCLUSION: Neither the time of the accident nor the severity of the driver's injury affected the frequency of legal prosecution of the driver. The conviction rate in this study was much greater than that reported in previous studies. Despite increased public awareness of the dangers of drunk driving, culpable individuals continue to escape legal prosecution.

For additional information or a copy of the complete study, contact Steve Pandelidis, MD, at the York Hospital Department of Surgery, (717) 771-2202.

The editors of PENNSYLVANIA MEDICINE encourage submission of scientific articles for publication consideration; however, abstracts of those articles not published in full are printed as a reference for readers. Please send submissions to: Medical Editor, PENNSYLVANIA MEDICINE, 777 East Park Drive, P.O. Box 8820, Harrisburg, PA 17105-8820. Full scientific articles are published at the discretion of the medical editor as consistent with the editorial schedule and are subject to editing.

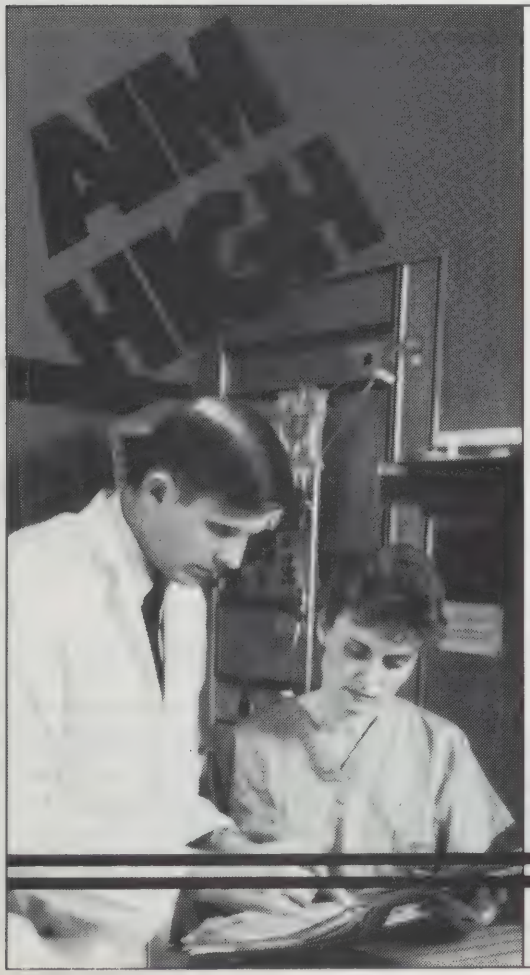


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AIR FORCE

William J. Kelly, MD, past president of the State Society, and a founding and charter board member of the Pennsylvania Medical Society Liability Insurance Company (PMSLIC), has retired from PMSLIC's Board of Trustees after 16 years of service. A celebration was held in March to honor his dedication, which included serving as chairman of PMSLIC's Underwriting Committee and as a member of its Executive, Finance, and Marketing committees. Dr. Kelly, an internist at St. Francis Hospital in Pittsburgh, received his medical degree from St. Louis University in Missouri.


Dr. Kelly

Hans Hamilton Liu, MD, was appointed chief of infectious diseases at Presbyterian Medical Center of Philadelphia.

Daniel Hyman, MD, pediatrician at Chestnut Hill Hospital, received the Governor's Highway Safety Award in the safety education category for establishing the Springfield Township Bicycle Helmet Safety Campaign. Dr. Hyman instituted the campaign in 1990 to increase awareness, support, and use of bicycle safety helmets.

Allan Robert Tunkel, MD, PhD, was appointed assistant professor of medicine in the Division of Infectious Diseases and assistant program director of the medical residency training program at the Medical College of Pennsylvania.

Leonard H. Finkelstein, DO, president and chairman of the Osteopathic Medical Center of Philadelphia, was instrumental in establishing the new Quality Assessment/Utilization Review Department at the Philadelphia College of Osteopathic Medicine (PCOM). **Toni Maria Casale, DO, FACURP, MPA,** a PCOM graduate, will chair the department.

Burton L. Eisenberg, MD, associate professor of surgery at Temple University Medical School and clinical associate professor of surgery at the Uniformed Services University of Health Sciences in Maryland, has been named chairman of the Department of Surgical Oncology at Fox Chase Cancer Center in Philadelphia.

Rosemary Rudolph Shy, MD, was appointed staff pediatrician at Children's Rehabilitation Hospital of Thomas Jefferson University.

Matthew Stern, MD, director of the Graduate Hospital's Parkinson's Disease and Movement Disorders Center, served as chairman of "Clinical and Therapeutic Aspects of Parkinsonism." The two-day symposium, held in Moscow, gathered experts on Parkinson's disease from the United States and the Soviet Union to share their knowledge and learn from others' experiences. Dr. Stern worked for four years to develop and organize the event.

James H. Gault, MD, FACC, chief of cardiology at Lancaster General Hospital, this month began an 18-month term as president of the Eastern Pennsylvania Chapter of the American College of Cardiology.


Dr. Gault

Robert C. Aber, MD, past associate dean for student and alumni affairs at Penn State's Milton S. Hershey Medical Center, was appointed associate dean for medical education. He also serves as assistant dean for external relations.

Leon S. Malmud, MD, Herbert M. Stauffer professor of diagnostic imaging and vice president for the Temple University Health Sciences Center, participated in a workshop on molecular nuclear medicine sponsored by Medical Applications and Environmental Research of the Department of Energy in Washington, DC.


Dr. Malmud

Norman M. Krause, MD, specialist in orthopedic surgery and sports medicine, was elected president of the medical staff at the Greater Pittsburgh Rehab Hospital.

Charles E. Mangan, MD, has been appointed chief of gynecologic oncology at Pennsylvania Hospital.

Andrew C. Krouskop, MD, was appointed senior vice president of medical affairs and a member of the board of trustees at Harmarville Rehabilitation Center, as well as chief operating officer of Harmarville's Community Outreach physician's practice plan. Also named to the Harmarville Board of Trustees was **James E. Hertzog, MD,** corporate medical director for Consol, Inc., and Remington Arms Company, Inc.

Joseph A. Marasco Jr., MD, chairman of radiology at St. Francis Medical Center, Forbes Health System, and Ohio Valley General Hospital, was elected treasurer of the International Society of Radiology.

Dorothy I. Lansing, MD, gynecologist, author, and medical historian from Paoli, received a Distinguished Alumna Service Award from Indiana University for her contributions to the school and her work in developing a lectureship for medical schools about sexually transmitted diseases.

Levi Stanform Downs Jr., a second-year medical student at the University of Pittsburgh School of Medicine, was awarded the Metropolitan Life Foundation Award for academic excellence in medicine.

Three physicians were honored with awards at the St. Francis Medical Center Department of Internal Medicine Residency Graduation Dinner: **Dominick Cannone, MD,** received the Subspecialty Attending of the Year Award; **Elmer J. Holzinger, MD,** received the Osler Clinical Medicine Award; and **John W. Hoyt, MD,** recieved the Professor of the Year Award.

Donald P. Atkinson, MD, FACS, general surgeon, received a three-year appointment as cancer liaison physician for the cancer program at Allegheny General Hospital.

Thomas A. Armstrong, MD, Hatboro, was elected president of the Inter-County Ophthalmological Society.

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Jeffrey L. Hassel, MD, specialist in internal medicine and director of the Transitional Level of Care Center at Community General Hospital in Reading, was installed as president of the Berks County Medical Society. Also installed were: **Gary M. Lattin, MD,** cardiologist, as president elect, and **Daniel B. Kimball Jr., MD,** director of medicine at Reading Hospital, as treasurer.

Paul S. Friedman, MD, Philadelphia, was elected fellow emeritus of the American College of Radiology.

Molakalmuru H. Murthy, MD, FACP, internal medicine and rheumatology specialist in Pittsburgh, and **Sushil K. Singhi, MD,** internal medicine and cardiology specialist at St. Francis Medical Center, have been elected to fellowship in the American College of Physicians.

Joel M. Lerman, MD, psychiatrist, was appointed assistant medical director of the Sanctuary at Northwestern in Fort Washington.

Thomas E. Starzl, MD, director of the University of Pittsburgh Transplantation Institute, was inducted into the National French Academy of Medicine. He was recognized for his pioneering work in organ transplantation.

Paul Angottis, DPM, North Wales, has been named chief of the Division of Podiatry at Abington Memorial Hospital.

John A. Power, MD, cardiologist at St. Francis Medical Center, served as principal investigator of a research team which recommended federal Food and Drug Administration approval of an excimer laser to open blocked cardiac bypass grafts.



Dr. Power

Kathleen Toomey, MD, JD, chief of medical genetics at St. Christopher's Hospital for Children in Philadelphia, has established a program which enables a newborn with problems to be diagnosed without being separated from his or her parents.

Francine L. Marcus, MD, Philadelphia psychiatrist, has been named director of the Adolescent Substance Abuse Program at the Institute of Pennsylvania Hospital.

Albert Einstein Medical Center Emergency Department physicians **Barry J. Burton, DO,** and **Brian A. Nester, DO,** received awards from the American Osteopathic Association: Dr. Burton received the Burroughs Wellcome Resident Leadership Award in recognition of community service, and Dr. Nester received the Fisons Pharmaceuticals Resident Award for his contribution to allergy/asthma education and research.

Jay Roberts, PhD, professor at the Medical College of Pennsylvania, and **Fred Lembeck, MD,** professor of medicine at the University of Graz, Austria, have developed an educational exchange in pharmacology. The program will allow select graduate students to study in Philadelphia and Graz for three months to one year.

E. Albert Reece, MD, Abraham Roth professor and chairman of the Temple University Department of Obstetrics, Gynecology, and Reproductive Services, was awarded an $80,000 grant from the American Diabetes Association to study why babies born to women with diabetes have an increased incidence of birth defects.

Diana Dickson-Witmer, MD, clinical assistant professor in surgery at Thomas Jefferson University Hospital's Medical College, received a statewide community service award from the American Medical Women's Association for her dedication to public health issues.



Dr. Dickson-Witmer

John Romano, MD, distinguished university professor emeritus of psychiatry at the University of Rochester School of Medicine and Dentistry, presented the Albert M. Biele, MD, Memorial Lecture at Jefferson Medical College on "The Battered Academician Syndrome."

Peter J. Savino, MD, director of neuro-ophthalmology service at Wills Eye Hospital, served as principal investigator of a national study on the treatment of optic neuritis. The results of the study were published in the February 27 issue of the *New England Journal of Medicine*.

Andrew K. Pollack, MD, Horsham, has been named physician in charge of dermatology at Chestnut Hill Hospital.



Sukh Dev Sharma, MD (r), Hamot Medical Center cardiologist, received the Mother India International Award during the third annual India-NRI (Non-Resident Indian) World Convention in New Dehli, India. The Honorable Shiv Raj Patil (l), speaker of India's national legislative assembly, presented the award.

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Hearing Irons: The Questioning "Y"

J. Mostyn Davis, MD

It was a day still remembered—the day we medical students got our stethoscopes. They were carefully folded over just enough so the earpieces were easily visible to the world in our white coat pockets. This instrument is to the future doctor what the badge is to the policeman, the white scarf is to the pilot, and the reverse collar is to the clergyman...a symbol of arrival at a goal, long dreamed of and worked for: we now knew we were accepted into the fraternity of medicine. Yet, the story of how the stethoscope came to be is frequently unappreciated.

We live and practice in times when "technological miracles" are commonplace. As we attempt to peer at the internal workings of our patients through the intact integument, we employ a bewildering array of devices, appliances, and procedures. Of course, we use our own senses—sight, smell, touch, hearing—but in addition there are invisible rays of all kinds, radioactive substances, sound waves, chemical tests, mechanical and hemodynamic manipulations, and even electromagnetic procedures.

The great desire to learn how the internal ravages of disease come about was, at least in part, a result of renewed interest in the autopsy. Clinical tracking of the natural history and course of the disease was followed by observation of the pathology produced, noted at the autopsy table. The postmortem examination provided a, so-to-speak, retrospective look for answers. Nearly 200 years previously, William Harvey had described the heart sounds, but because of maidenly modesty, obesity, or dislike of direct patient contact, few ears had been applied to the chests of patients.

In 1816, Dr. Renee Laennec first rolled three sheets of stiff paper together and connected his ear to a patient's chest. His new device needed a name, and, after considering several alternatives, he chose the name "stethoscope," from the Greek words *stethos* (chest) and *scopos* (observer). During its early years, it was sometimes called simply "le cylinder," the baton, or a solometer. However, the original name stuck, and a stethoscope it became.

As with so many medical advances, this device proved too high-tech at the time and had to wait for slow acceptance. Many physicians refused to recognize its importance. Although more slowly than in Europe, the new instrument began changing diagnosis in the still-young nation of America. Still, it was a number of years before it came to occupy an important place in American medicine. Harvard Medical School, for example, did not have a stethoscope until 1869, some 50 years after its invention by Dr. Laennec.

This new instrument was not merely a method to transmit sounds from the patient's chest to the listener's ear. Until now, the patient's description of the symptoms, unreliable as they might be, remained the sine qua non of the diagnosis. The stethoscope would now teach the difference between objective evidence and evidence provided by the patient or biased observer. Since Dr. Laennec's discovery, objective criteria have gradually become the primary objective of the medical examination.

The story most widely accepted about how Dr. Laennec was led to his momentous discovery involves a children's game of the time which consisted of scratching one end of a wooden beam and listening to the sounds produced at the other end. Supposedly, this idea occurred to him while he was contemplating how to listen to the heart sounds of a very obese female patient.[1]

As has been true in many other medical advances, others have claimed the honor of the stethoscope's invention. However, there seems little doubt that the discovery of this most significant medical instrument belongs to Dr. Laennec. Next time you remove that shiny instrument from your white coat pocket, think (kindly) of Dr. Laennec.

Dr. Davis is a family physician at Geisinger Medical Center, Danville. He is a former Society trustee and currently serves as editor of **Keystone Physician,** *an official publication of the Pennsylvania Academy of Family Physicians.*

References

1. **Salinsky, M.** Early chapters in the stethoscope's evolution. *JAMA*, 264(21):28171, 1990.

NEW MEMBERS

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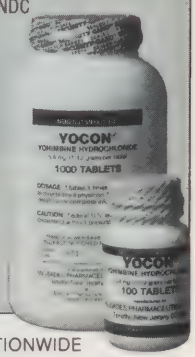
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References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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Gertrude W. Baldwin, MD, *Greensburg*
University of Pittsburgh, 1936; age 78, died January 13, 1992. Dr. Baldwin was an ophthalmologist.•

William W. Barkley, Jr., MD, *Waynesboro*
Temple University, 1943; age 73, died December 27, 1991. Dr. Barkley was a family practitioner.•

John J. Blizzard, MD, *Wallingford*
Jefferson Medical College, 1954; age 64, died December 15, 1991. Dr. Blizzard was an endocrinologist.•

Samuel Cohen, MD, *Blairsville*
University of Michigan School of Medicine, 1936; age 80, died December 8, 1991. Dr. Cohen was a general practitioner.•

Jacob S. Gordon, MD, *Wyncote*
Jefferson Medical College, 1933; age 84, died February 14, 1992. Dr. Gordon was a colon and rectal surgeon.•

Erle M. Heath, MD, *Pittsburgh*
University of Pittsburgh, 1940; age 74, died February 11, 1992. Dr. Heath was a family practitioner.•

Abraham S. Kaufman, MD, *Wyncote*
Temple University, 1935; age 80, died January 26, 1992. Dr. Kaufman was a cardiologist.•

Julius Mazer, MD, *Pittsburgh*
University of Pittsburgh, 1954; age 64, died December 20, 1991. Dr. Mazer was a radiologist.•

Thomas I. Metzgar, MD, *Stroudsburg*
Jefferson Medical College, 1928; age 90, died February 12, 1992. Dr. Metzgar was an ophthalmologist.•

Laborde E. Titus, MD, *Philadelphia*
University of Haiti, 1944; age 72, died February 9, 1992. Dr. Titus was a family practitioner.•

Joseph Alfieri, MD, *St. Marys*
University of Pittsburgh, 1961; age 61, died December 22, 1991. Dr. Alfieri was an internist.

Elmer M. Fritz, MD, *McKeesport*
University of Pittsburgh, 1950; age 65, died January 20, 1992. Dr. Fritz was an anesthesiologist.

Robert A. Holst, MD, *Latrobe*
University of Iowa, 1966; age 50. Dr. Holst was a neurosurgeon.

Barbara J. Owen, MD, *Villanova*
Kansas University Medical School, 1950; age 73, died December 25, 1991. Dr. Owen was a pathologist.

F. William Saul, MD, *Mechanicsburg*
Temple University; age 84, died January 9, 1992. Dr. Saul was a radiologist.

Lester R. Shelton, MD, *Wynnewood*
Hahnemann University, 1985; age 40, died January 30, 1992. Dr. Shelton was a psychiatrist.

John H. Wagner Jr., MD, *Oakmont*
University of Pittsburgh, 1952; age 67, died January 20, 1992. Dr. Wagner was a general surgeon.

G. Randolph Wilson, MD, *Pittsburgh*
Medical College of Virginia, 1932; age 87, died January 9, 1992. Dr. Wilson was an obstetrician.

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General internist—Immediate opening available for dynamic BC/BE physician to join well-established internal medicine practice in southwestern Pennsylvania. Salary $100,000. Benefit package $10,000. Pension plans. Future partnership option. In-house laboratory and x-ray facilities. Excellent opportunity. Reply Box 345, PENNSYLVANIA MEDICINE, 777 East Park Dr., P.O. Box 8820, Harrisburg, PA 17105-8820.

Pocono Mts. area—Northeast Pennsylvania busy family practice looking for BE/BC family practitioner. No Ob; active hospital practice; partnership possibilities. Skiing, boating, hiking within 5 miles. 90 minutes from Manhattan and Philadelphia. Please send CV to: Monroe Family Practice Assoc., 1803 W. Main, Stroudsburg, PA 18360; (717) 421-0170.

Surgery—The Department of Surgery at a progressive, academic urban medical center in the northeast seeking aggressive, well-trained chief of vascular surgery and a general surgeon with certificate in critical care to develop a practice and play an important role in the education and training of medical students and surgical residents. Hospital will provide attractive package and incentives and will assist with practice development. Medical school faculty appointment commensurate with qualifications. Box 362, PENNSYLVANIA MEDICINE, 777 East Park Dr., P.O. Box 8820, Harrisburg, PA 17105-8820.

OB/GYN, PEDS, FP, ONC—Group practice opportunities, Philadelphia area, confidentiality protected. Contact Al Yannelli, Yannelli Randolph & Co., 994 Old Eagle School Rd., Ste. 1020, Wayne, PA 19087 (215) 964-1616.

Pittsburgh, Pennsylvania—Penn Group Medical Association (PGMA), a multi-specialty group practice affiliated with the largest HMO in Pittsburgh, is seeking BE/BC physician in: family practice, internal medicine, pediatrics, ob/gyn, and psychiatry. We are formally affiliated with major teaching hospitals and leading community hospitals in Pittsburgh. PGMA serves seven ambulatory care centers, all conveniently located near cultural, educational, recreational, and corporate activities. Excellent salary, fringe benefits, and incentives. For confidential consideration contact: Angela Lascola, HealthAmerica, 5 Gateway Center, Pittsburgh, PA 15222 or call collect (412) 553-7502.

Immediate position—Part-time BC/BE internist. Southwestern Pennsylvania (suburb of Pittsburgh); ideal position for female physician desiring to raise a family and practice medicine. Modern new facility, x-ray, lab. Salary negotiable. Box 366, PENNSYLVANIA MEDICINE, 777 East Park Dr., P.O. Box 8820, Harrisburg, PA 17105-8820.

Emergency Department position. 30,000 visits/year. Growing comprehensive community hospital in north central Pennsylvania. Excellent reimbursement. Forward CVs to George A. Manchester, Medical Director's Office, Divine Providence Hospital, 1100 Grampian Blvd., Williamsport, PA 17701.

Emergency Department position. 11,000 visits/year. Small

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Ophthalmology	Philadelphia	$ 300,000
Ophthalmology	Michigan	$ 700,000
Ophthalmology	North Virginia	$1,000,000
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Pediatrics	Fort Lauderdale, FL	$ 400,000
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Pediatrics	Lehigh Valley, PA	$ 250,000
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For additional information, please contact:

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stable community hospital affiliated with larger hospital, north central Pennsylvania. Forward CVs to: Stan H. Swartz, MD, Muncy Valley Hospital, Emergency Department, 215 East Water St., Muncy, PA 17756.

Seeking associate for busy family practice in western Pennsylvania area. Salary and benefits guaranteed with full partnership available in one year. Transportation and accommodations paid for meeting. Contact Chris at (412) 758-7524 or reply to U.G. Kim, MD, P.O. Box 868, Ellwood City, PA 16117.

Wanted—Family physician needed for busy broadbased group practice 35 minutes north of Pittsburgh. Practice includes obstetrics, nursing home work, house calls, and assisting in surgery. Contact: Family Medical Care Associates (412) 681-5170.

General Internist—Excellent opportunity (Full or Part-time). Immediate opening for industrious, personable, compassionate BC-BE physician to join a well established internal medicine practice in greater Harrisburg area. In house laboratory and x-ray facilities. Special skills helpful but not necessary. Reply to: Box 372, PENNSYLVANIA MEDICINE , 777 East Park Dr., P.O. Box 8820, Harrisburg, PA 17105-8820.

BC/BE internist or F.P. physician for practice near Chestnut Hill. Competitive salary and excellent benefits. Reply to: L. Kessel, MD, 8200 Henry Ave., G-1, Philadelphia, PA 19128.

Emergency Physician—Full-time opportunities in the PA, NY, and NJ area. Must be experienced. Board eligibility and ACLS, ATLS certifications preferred. Excellent compensation package plus malpractice insurance and benefits. Part-time position also available. Send CV to AESA, Inc., Box 2510, Wilkes-Barre, PA 18703; or call 1-800-779-1427.

Community Hospital, N.E. Philadelphia—2 locations. Seeks general radiologist, mammo, ultrasound, cat scan, nuc. med. Knowledge of angio helpful but not necessary. 2 positions: full & part-time. Send resume & date available to: Ann Gabriel, MBA, P.O. Box 21911, Philadelphia, PA 19124.

Solo board certified family physician seeking a BE/BC non-smoking associate in Family Practice. No OB. Modern office, good staff, good salary. Contact James H. Thomas, MD, Eastwood Professional Building, Greensburg, PA 15601; (412) 837-5257.

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General internist, or pulmonary, cardiology or other subspecialty-BE/BC to join 5-physician group in Carlisle, south central Pennsylvania. Close to Washington, Baltimore, Philadelphia. College town with progressive hospital, excellent schools, good place to raise family. Competitive salary with complete benefit package, opportunity for partnership. Send CV to Box 374, PENNSYLVANIA MEDICINE, 777 East Park Drive, P.O. Box 8820, Harrisburg, PA 17105-8820.

Full-time emergency room position available in a 400-bed suburban hospital with 48,000 visits. Board certified/eligible in emergency medicine or other specialty with emergency room experience. Excellent salary/benefit package with partnership potential. Contact Clarke Hankey, MD, Emergency Department, St. Clair Hospital, 1000 Bower Hill Road, Pittsburgh, PA 15243 (412) 561-4900.

Emergency Physicians—St. Agnes Medical Center, Philadelphia, Pennsylvania, a 236 bed acute care community hospital with affiliated teaching programs, is seeking an emergency medicine group to furnish 24 hours per day and 7 days per week coverage for an emergency department with 18,000 visits per year. Qualifications: Board certification plus pediatric and adults ACLS. July 1, 1992 availability. Contact Emergency Department Search Committee, 1900 South Board Street, Philadelphia, PA 19145, (215) 339-4226.

Board Certified/Board Eligible Family Practice and Pediatric Physicians—Needed at Dunham Army Health Clinic, Pennsylvania. Forty hours per week, no nights, no call, no weekends. Army civilian positions with liberal benefit package including full malpractice coverage. Salary commensurate with experience ranging from $70-81,000. Contact Colonel Bailey at (717) 245-3041.

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Practice Wanted—Experienced family physician 15 years in practice, wants to buy general/family medicine practice in Chester, Montgomery, Philadelphia, Delaware, or Lancaster counties. Please call (215) 495-5414 or 495-5355.

Seeking position in gastroenterology/internal medicine. Available now. Board certified in internal medicine. Board eligible in gastroenterology. British and U.S. trained. Licensed in Pennsylvania. Contact S.P. Nathan, South Baltimore General Hospital, 3001 S. Hanover St., Baltimore, MD 21230. (301) 355-5502.

Universal X-Ray Equipment—Manufactured in 1984. No flouroscopy. X-ray table, film processor, Fisher Industries. All three items bought new and used lightly. Call (412) 547-0770.

For Sale—Established pediatric practice in the western suburbs of Philadelphia. Fully equipped. 1,600 patients. Doctor retiring. Box 377, PENNSYLVANIA MEDICINE, 777 East Park Drive, P.O. Box 8820, Harrisburg, PA 17105-8820.

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Medicare Can Learn From Playskool

John W. Mills, MD
Medical Editor

One of the first lessons we learn as children is the simple truth that a square object won't fit into a round hole. Playskool, Inc., has a model street-side postal box with various geometric openings and a similar number of geometric objects, each of which will only fit into the proper opening. The lesson, of course, is to teach us at an early age that square objects go into square holes and that trying to get a round object into a square hole doesn't work.

As we mature, we relate the lesson to our human experience and constantly modify our psycho-social milieu so that we can fit into a particular niche. If one is adept at modifications, one may fit into other niches. But in practical terms, a round object will not fit into a square hole.

As I've fumbled with the new Medicare evaluation codes for the past few months, my grandchildren's Playskool toy broke through my subconscious. Ergo, all patients entering my office *do not* fit into the 10 defined office codes; and try as I may, I cannot reshape these patients to fit the codes.

The truth of the matter is that the computer experts have tried to fit all patients—diverse human beings, none of whom is the same—into 10 evaluation codes. Obviously, they have never treated patients, and they probably never had a Playskool post office!

Look at another facet of the codes: the whole system is problem-oriented. If a patient has no complaints or simply wants a physical, but is *not* sick (e.g., "no definable problem"), then that patient won't fit into a code. Simply put, the physician won't get reimbursed for the office visit unless a definable problem is "manufactured." To put it another way, if not sick as defined by the codes, a patient has no business seeing a physician.

"Medicare's refusal to pay for preventive care is a retrograde stance."

This leads me to wonder what is *really* is at the core of the new Medicare system. There are those in our profession who firmly believe that an unidentified contigency of "federal staffers" have, for years, been doggedly working behind the scenes to bring about the complete federalization of the U.S. health care system. This premise seems to hold some truth because all Blue Cross/Blue Shield plans have or will soon adopt the new codes, and other insurance carriers will no doubt do the same very quickly. Thus, since the system won't reimburse for preventive medicine visits (e.g., "not sick" and "no problem"), we've got a system that won't pay physicians to keep patients well and will only pay for illnesses. Physicians are forced to be crisis-oriented.

It is an established fact that preventive care saves money in the long run. If I pick up an early *in situ* cancer of the cervix, the cost of treatment with most probable cure is far less expensive than if I diagnosed a Stage III cancer of the cervix. The same can be said of almost any catastrophic illness: preventive care may totally avoid many of these conditions; and certainly, early diagnosis in the preventive visit is far less costly than the advanced disease with its diagnosis and treatment. Also, it goes without saying that the quality of life is a plus when preventive care and early diagnosis are routine.

Perhaps I wandered a bit, but I think the whole new reimbursement system has taken medicine back 75 years. The only time one went to a doctor then was for illness. Preventive medicine wasn't considered, perhaps because we didn't have the tools to do a decent job. Medicare's refusal to pay for preventive care is a retrograde stance. All patients do *not* fit the 10 evaluation codes—round patients (no pun intended) do *not* fit into square codes.

Dr. Mills, State Society trustee from the Ninth District, specializes in gynecology in Indiana.



WHEN ACID REFLUX ERUPTS

Zantac® 150 Tablets
(ranitidine hydrochloride)

Zantac® 300 Tablets
(ranitidine hydrochloride)

Zantac® Syrup
(ranitidine hydrochloride)

BRIEF SUMMARY

The following is a brief summary only. Before prescribing, see complete prescribing information in Zantac® product labeling.

INDICATIONS AND USAGE: Zantac® is indicated in:
1. Short-term treatment of **active duodenal ulcer.** Most patients heal within 4 weeks.
2. **Maintenance therapy** for duodenal ulcer patients at reduced dosage after healing of acute ulcers.
3. The treatment of **pathological hypersecretory conditions** (e.g., Zollinger-Ellison syndrome and systemic mastocytosis).
4. Short-term treatment of **active, benign gastric ulcer.** Most patients heal within 6 weeks and the usefulness of further treatment has not been demonstrated.
5. Treatment of **gastroesophageal reflux disease (GERD).** Symptomatic relief commonly occurs within 1 or 2 weeks after starting therapy. Therapy for longer than 6 weeks has not been studied.

In active duodenal ulcer; active, benign gastric ulcer; hypersecretory states; and GERD, concomitant antacids should be given as needed for relief of pain.

CONTRAINDICATIONS: Zantac® is contraindicated for patients known to have hypersensitivity to the drug.

PRECAUTIONS:

General: 1. Symptomatic response to Zantac® therapy does not preclude the presence of gastric malignancy.
2. Since Zantac is excreted primarily by the kidney, dosage should be adjusted in patients with impaired renal function (see DOSAGE AND ADMINISTRATION). Caution should be observed in patients with hepatic dysfunction since Zantac is metabolized in the liver.

Laboratory Tests: False-positive tests for urine protein with Multistix® may occur during Zantac therapy, and therefore testing with sulfosalicylic acid is recommended.

Drug Interactions: Although Zantac has been reported to bind weakly to cytochrome P-450 *in vitro,* recommended doses of the drug do not inhibit the action of the cytochrome P-450-linked oxygenase enzymes in the liver. However, there have been isolated reports of drug interactions that suggest that Zantac may affect the bioavailability of certain drugs by some mechanism as yet unidentified (e.g., a pH-dependent effect on absorption or a change in volume of distribution).

Increased or decreased prothrombin times have been reported during concurrent use of ranitidine and warfarin. However, in human pharmacokinetic studies with dosages of ranitidine up to 400 mg per day, no interaction occurred; ranitidine had no effect on warfarin clearance or prothrombin time. The possibility of an interaction with warfarin at dosages of ranitidine higher than 400 mg per day has not been investigated.

Carcinogenesis, Mutagenesis, Impairment of Fertility: There was no indication of tumorigenic or carcinogenic effects in lifespan studies in mice and rats at dosages up to 2,000 mg/kg per day.

Ranitidine was not mutagenic in standard bacterial tests (*Salmonella, Escherichia coli*) for mutagenicity at concentrations up to the maximum recommended for these assays.

In a dominant lethal assay, a single oral dose of 1,000 mg/kg to male rats was without effect on the outcome of two matings per week for the next 9 weeks.

Pregnancy: ***Teratogenic Effects: Pregnancy Category B:*** Reproduction studies have been performed in rats and rabbits at doses up to 160 times the human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Zantac. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: Zantac is secreted in human milk. Caution should be exercised when Zantac is administered to a nursing mother.

Pediatric Use: Safety and effectiveness in children have not been established.

Use in Elderly Patients: Ulcer healing rates in elderly patients (65 to 82 years of age) were no different from those in younger age-groups. The incidence rates for adverse events and laboratory abnormalities were also not different from those seen in other age-groups.

ADVERSE REACTIONS: The following have been reported as events in clinical trials or in the routine management of patients treated with Zantac®. The relationship to Zantac therapy has been unclear in many cases. Headache, sometimes severe, seems to be related to Zantac administration.

Central Nervous System: Rarely, malaise, dizziness, somnolence, insomnia, and vertigo. Rare cases of reversible mental confusion, agitation, depression, and hallucinations have been reported, predominantly in severely ill elderly patients. Rare cases of reversible blurred vision suggestive of a change in accommodation have been reported.

Cardiovascular: As with other H_2-blockers, rare reports of arrhythmias such as tachycardia, bradycardia, atrioventricular block, and premature ventricular beats.

Gastrointestinal: Constipation, diarrhea, nausea/vomiting, abdominal discomfort/pain, and rare reports of pancreatitis.

Hepatic: In normal volunteers, SGPT values were increased to at least twice the pretreatment levels in 6 of 12 subjects receiving 100 mg q.i.d. intravenously for 7 days, and in 4 of 24 subjects receiving 50 mg q.i.d. intravenously for 5 days. There have been occasional reports of hepatitis, hepatocellular or hepatocanalicular or mixed, with or without jaundice. In such circumstances, ranitidine should be immediately discontinued. These events are usually reversible, but in exceedingly rare circumstances death has occurred.

Musculoskeletal: Rare reports of arthralgias.

Hematologic: Blood count changes (leukopenia, granulocytopenia, thrombocytopenia) have occurred in a few patients. These were usually reversible. Rare cases of agranulocytosis, pancytopenia, sometimes with marrow hypoplasia, and aplastic anemia and exceedingly rare cases of acquired immune hemolytic anemia have been reported.

Endocrine: Controlled studies in animals and man have shown no stimulation of any pituitary hormone by Zantac® (ranitidine HCl) and no antiandrogenic activity, and cimetidine-induced gynecomastia and impotence in hypersecretory patients have resolved when Zantac has been substituted. However, occasional cases of gynecomastia, impotence, and loss of libido have been reported in male patients receiving Zantac, but the incidence did not differ from that in the general population.

Integumentary: Rash, including rare cases suggestive of mild erythema multiforme, and, rarely, alopecia.

Other: Rare cases of hypersensitivity reactions (e.g., bronchospasm, fever, rash, eosinophilia), anaphylaxis, angioneurotic edema, and small increases in serum creatinine.

OVERDOSAGE: Information concerning possible overdosage and its treatment appears in the full prescribing information.

DOSAGE AND ADMINISTRATION: (See complete prescribing information in Zantac® product labeling.)

Active Duodenal Ulcer: The current recommended adult oral dosage is 150 mg or 10 mL (2 teaspoonfuls equivalent to 150 mg of ranitidine) twice daily. An alternate dosage of 300 mg or 20 mL (4 teaspoonfuls equivalent to 300 mg of ranitidine) once daily at bedtime can be used for patients in whom dosing convenience is important. The advantages of one treatment regimen compared to the other in a particular patient population have yet to be demonstrated.

Maintenance Therapy: The current recommended adult oral dosage is 150 mg or 10 mL (2 teaspoonfuls equivalent to 150 mg of ranitidine) at bedtime.

Pathological Hypersecretory Conditions (such as Zollinger-Ellison syndrome): The current recommended adult oral dosage is 150 mg or 10 mL (2 teaspoonfuls equivalent to 150 mg of ranitidine) twice a day. In some patients it may be necessary to administer Zantac® 150-mg doses more frequently. Dosages should be adjusted to individual patient needs, and should continue as long as clinically indicated. Dosages up to 6 g per day have been employed in patients with severe disease.

Benign Gastric Ulcer: The current recommended adult oral dosage is 150 mg or 10 mL (2 teaspoonfuls equivalent to 150 mg of ranitidine) twice a day.

GERD: The current recommended adult oral dosage is 150 mg or 10 mL (2 teaspoonfuls equivalent to 150 mg of ranitidine) twice a day.

Dosage Adjustment for Patients with Impaired Renal Function: On the basis of experience with a group of subjects with severely impaired renal function treated with Zantac, the recommended dosage in patients with a creatinine clearance less than 50 mL/min is 150 mg or 10 mL (2 teaspoonfuls equivalent to 150 mg of ranitidine) every 24 hours. Should the patient's condition require, the frequency of dosing may be increased to every 12 hours or even further with caution. Hemodialysis reduces the level of circulating ranitidine. Ideally, the dosing schedule should be adjusted so that the timing of a scheduled dose coincides with the end of hemodialysis.

HOW SUPPLIED: Zantac® 300 Tablets (ranitidine hydrochloride equivalent to 300 mg of ranitidine) are yellow, capsule-shaped tablets embossed with "ZANTAC 300" on one side and "Glaxo" on the other. They are available in bottles of 30 (NDC 0173-0393-40) tablets and unit dose packs of 100 (NDC 0173-0393-47) tablets.

Zantac® 150 Tablets (ranitidine hydrochloride equivalent to 150 mg of ranitidine) are white tablets embossed with "ZANTAC 150" on one side and "Glaxo" on the other. They are available in bottles of 60 (NDC 0173-0344-42) and 100 (NDC 0173-0344-09) tablets and unit dose packs of 100 (NDC 0173-0344-47) tablets.

Store between 15° and 30°C (59° and 86°F) in a dry place. Protect from light. Replace cap securely after each opening.

Zantac® Syrup, a clear, peppermint-flavored liquid, contains 16.8 mg of ranitidine hydrochloride equivalent to 15 mg of ranitidine per 1 mL in bottles of 16 fluid ounces (one pint) (NDC 0173-0383-54).

Store between 4° and 25°C (39° and 77°F). Dispense in tight, light-resistant containers as defined in the USP/NF.

September 1991

Glaxo Pharmaceuticals™
DIVISION OF GLAXO INC.
Research Triangle Park, NC 27709

Zantac® Syrup:
Manufactured by Roxane Laboratories, Inc., Columbus, OH 43216

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Zantac® Tablets
ranitidine HCl/Glaxo 150 mg tablets bid
WHEN ACID REFLUX ERUPTS
Please see Brief Summary of Prescribing Information on adjacent page.
Glaxo/ ROCHE

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VOLUME 95 • NUMBER 5
MAY 1992

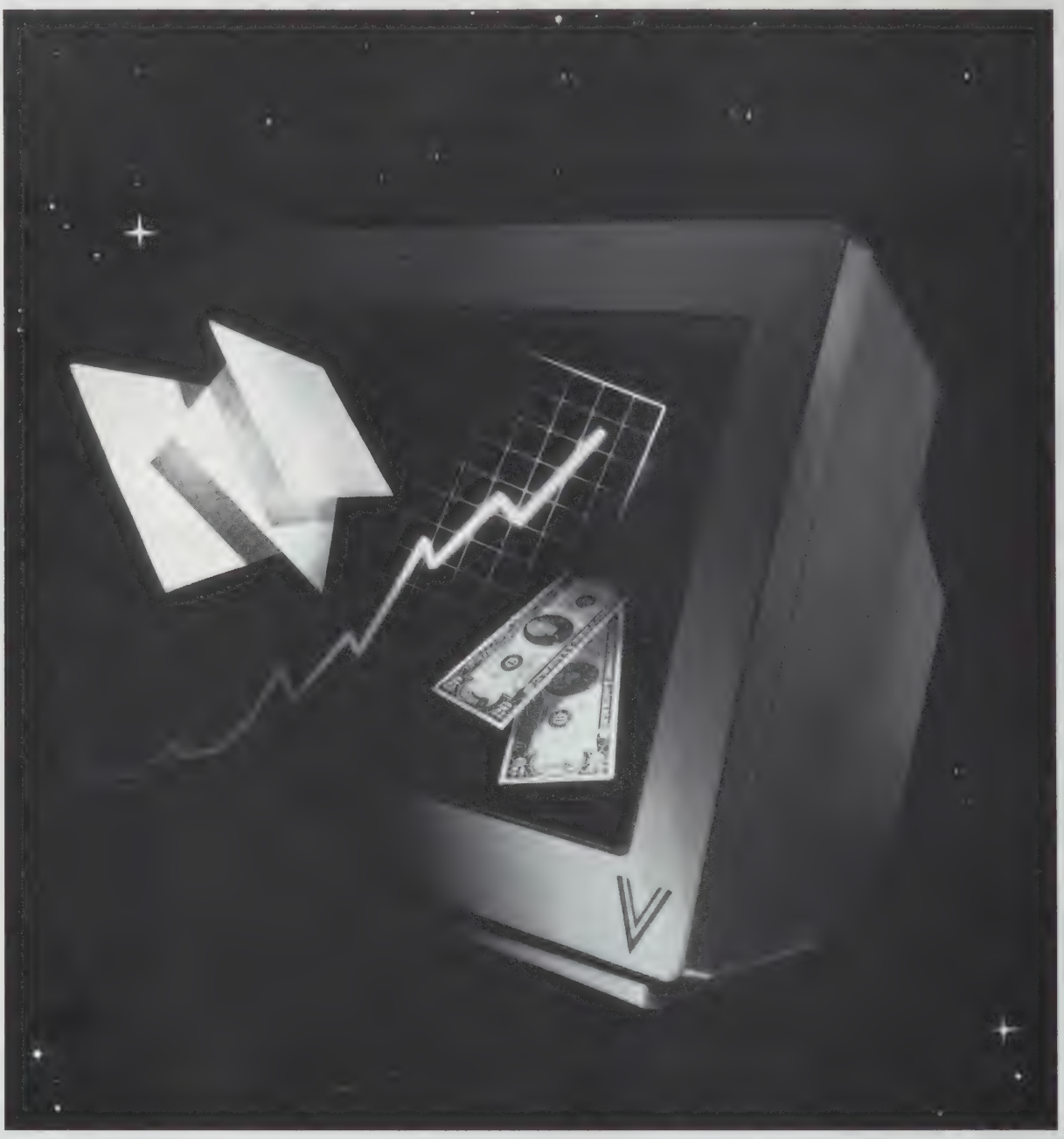


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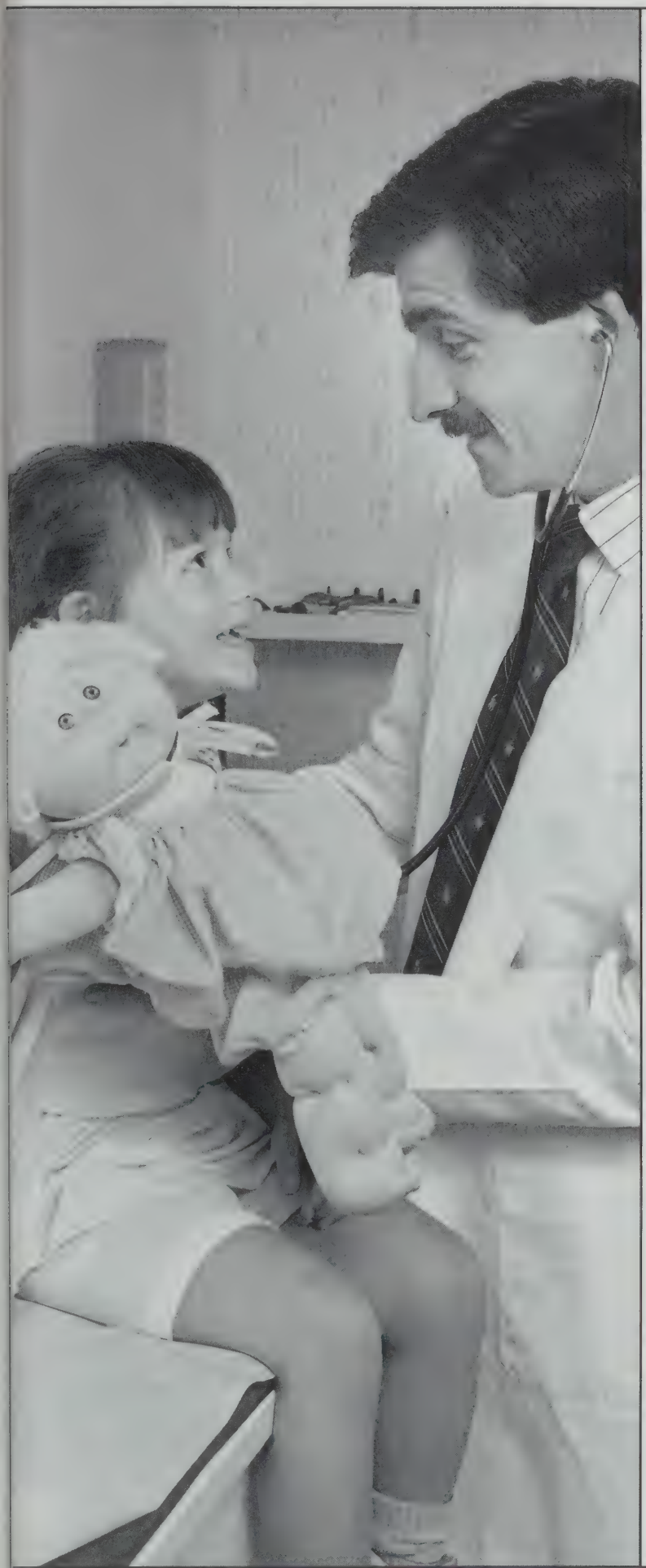
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Cover photo by John Wright, State Society director of public affairs: Physicians and health care leaders from around the state rallying at Harrisburg's state capitol building in March for fair reform on worker's compensation legislation.

PENNSYLVANIA MEDICINE (ISSN 0031-4595) is published monthly by the Pennsylvania Medical Society, 777 East Park Drive, Harrisburg, PA 17111.
SUBSCRIPTIONS: $20 per year— United States and Canada; $30—all others. Single issues $3.00 per copy prepaid; special issues cost more.
POSTMASTER: Send address changes to PENNSYLVANIA MEDICINE, 777 East Park Drive, PO Box 8820, Harrisburg, PA 17105–8820. Second class postage paid at Harrisburg, PA 17105.

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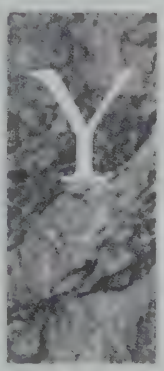
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SOCIETY REVISES LIVING WILL BROCHURE: The State Society has revised its living will brochure to reflect the Commonwealth's new Advance Directive for Health Care Act. The brochure describes how to prepare a living will, answers related questions, and provides a wallet card. The card, when completed, serves as notification that a person has signed an advance directive and indicates where a copy can be obtained. State Society members may receive 25 copies of the brochure free-of-charge upon request; printing and shipping costs will be charged for quantities of 100 or more brochures. To place an order, request a brochure order form from county or specialty societies, or call the Society at 1-800-228-7823. The general public may obtain individual copies of the brochure free-of-charge by sending a stamped, self-addressed envelope to the Society with a note requesting one brochure. County, state, and other health organizations in need of large quantities of the brochure, will also be informed of the opportunity to purchase copies.

PHYSICIANS REMINDED OF OSHA DEADLINE: Physicians are reminded that May 5 was the deadline for the Exposure Control Plan required by the new bloodborne pathogens regulations released by OSHA. Although physicians may not be cited without employee complaint on other regulations not yet in effect, they may be cited for violations of the control plan provision. Other implementation deadlines: training and record-keeping provisions—June 4, 1992; all other provisions—July 6, 1992. After each implementation, physicians should be aware that OSHA may cite, without complaint, for violations of any provisions in effect. An information kit created by the Society is available to provide members with compliance materials. For ordering information, see the May issue of *Executive Report*.

HCFA REVISES GROUP SETTING DEFINITION OF "NEW PATIENT VISIT": HCFA revised in April the current definition of a "new patient visit" for a group practice or clinic where all physicians are billing under an assignment account. The existing definition considered a patient as "new" only if the patient had not been seen by any member of the group, regardless of specialty, in the previous three-year period. The revised policy considers a patient "new" to the physician if the patient was not seen in the previous three-year period by a physician of the same specialty in that group.

MEDICARE INCREASES TECHNICAL COMPONENT RVUs: Effective for services rendered on or after April 13, 1992, Medicare has increased the technical component relative value units (RVUs) for approximately 170 diagnostic procedure codes. Although no professional component increases will occur for these codes, as a result of technical component increases, global RVUs also will increase. Payment increases will range from pennies to several dollars, with some of the biggest increases occurring for cardiac catheterization codes 93524, 93526, and 93527. The changes are a result of a new methodology used by Medicare to calculate technical components and a misapplication of the transition rules for a number of 1992 payment amounts.

GOVERNOR NOMINATES INSURANCE COMMISSIONER: Governor Robert P. Casey has nominated Cynthia M. Maleski of Allegheny County for the position of state insurance commissioner. She has been general counsel for Mercy Hospital in Pittsburgh since 1981 and will begin serving as acting commissioner on May 11, pending Senate vote on confirmation.

INSURANCE DEPARTMENT APPROVES "SPECIAL CARE" PROGRAM: The state Insurance Department has approved the "Special Care" program, to be offered by Blue Cross and Blue Shield beginning this month, which targets individuals and families not currently covered by health insurance. It will cost about half the price of standard health insurance coverage for those who qualify.

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New OSHA Rules Prompt Return to Crisis Mode

John W. Mills, MD
Medical Editor

Once again, the Pennsylvania Medical Society and the state's physicians are in a crisis mode. We had barely returned to normalcy after the adoption of the new RBRVS fee schedule mandated by Medicare, when OSHA (the Occupational Safety and Health Administration, U.S. Department of Labor) descended on us with the full force of their new regulations on occupational exposure to bloodborne pathogens. Originally published in final form on December 6, 1991, they are to be fully implemented by all health care facilities, including doctors' offices, by July 6, 1992.

"In a space of less than four months, we are dealing with another monumental change."

In a space of less than four months, we are dealing with another monumental change. Universal precautions have been around for some time, but perhaps most health care facilities have not incorporated them 100 percent into their daily routines. I wonder why we've been given only six months to implement the new OSHA regulations. What's the rush?

The HIV and HBV epidemic has been here for a while, and we know it's getting worse. Unfortunately, the whole subject has been treated like a political football instead of an infectious disease. The presidential election year may be the reason the Bush Administration is doing something on a significant health care issue.

Health care personnel—physicians in particular—don't have a problem with the new OSHA regulations. However, many of us feel the timetable is unreasonable and will serve to promote a myriad of entrepreneurs selling all kinds of "necessary equipment and supplies" to harried physicians.

The State Society has been deluged with calls from physicians desperate to attend one of the late April special seminars on the OSHA regulations. Fortunately, our Society has been able to gear up to meet the need; and staff, under Roger Mecum, executive vice president, have been quickly responsive.

In some respects, these regulations seem like "gilding the lily," if what we know of the communicability and transmission of HIV and HBV is true, and the Centers for Disease Control is not playing games with us. Why should it be necessary for an office secretary to wear an impervious gown, face mask, and protectice eye glasses to clean up a patient's vomitus in the waiting room, if the viruses are quickly inactivated by room temperature and clorox solution, and require a direct blood-entry portal?

First, we hear how difficult it is to acquire HIV or HBV unless from a contaminated blood transfusion, a significant need stick, or sexual involvement with an infected person. Now, it seems we are being required to bend over backwards—in unreasonable "jig-time"—to abide by OSHA regulations aimed at protecting health care professionals and our office staffs in the office setting, where transmission is unlikely with reasonable universal precautions. Couple the rush with OSHA's longstanding "KGB attitute/ power," and we have reason for our crisis mode.

The monetary fines for non-compliance are astronomical and could easily put a small practitioner out of business and into bankruptcy. Educational visits by OSHA may be the "order of the day" from the March 6 beginning until the final July 6 full implementation; but after that day, you can expect the "book to be thrown at you."

Is it all necessary? Are the fines within reason based on our medical knowledge of HIV and HBV? While I doubt it, as a good physician I am willing to comply if the regulations benefit society and our profession without unnecessary or unreasonable stress and cost. Time will tell.

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— Daniel Goldberg
MIIX President

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Facing Tough Political Realities

Robert N. Moyers, MD



When President George Bush saw the numbers for his opponent, Pat Buchanan, in the early primaries, he acknowledged that the voters were sending him a message and pledged to redouble his efforts to turn the economy around. "The real struggle," said one aide, "is not to overreact."

When Democratic candidate Bill Clinton heard the news of opponent Jerry Brown's win in Connecticut, he predicted many who voted against him in the primary would vote for him in the general election. "It's a long process," said an aide, "and I think people voted to keep the process going, keep it open, and learn more about the candidates. And that's all right."

What can physicians learn from these two incidents in this year's presidential campaign? We can learn how professional politicians react when the going is tough.

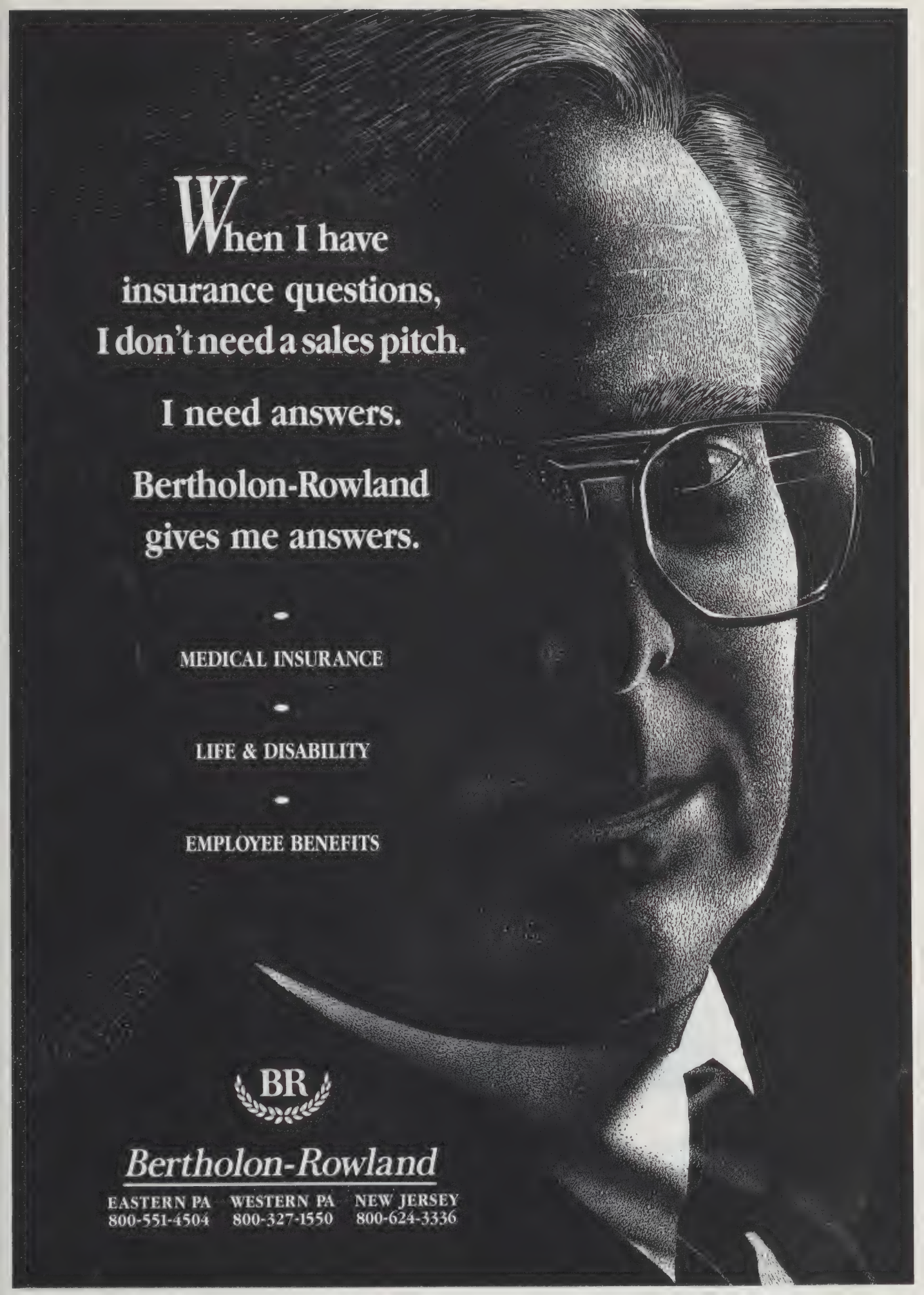
There are similarities in the ways both candidates, two very different men, handled these situations. First, they didn't deny the facts; they admitted that things did not go their way. Second, they looked carefully at what they might do differently. Third, they brought renewed energy to the task of turning things around. And last, they did not waste time blaming the process that led to their setbacks. As we look at our long and still-unresolved engagement in the state legislature over the issue of workers' compensation reform, we do well to keep these lessons before us.

We continue to devote enormous amounts of time and effort to carrying our position to Pennsylvania's administration and legislature. The Society's Quick Response Committee on workers' compensation meets frequently in person and through telephone conference calls. Members and staff devote many hours to doing research; drafting proposed language for legislation and amendments; and meeting with representatives of hospitals, business, insurance, and labor, as well as with key legislative contacts. The Society's governmental affairs staff have a combined total of more than 30 years' experience on the hill.

The Society's membership is fortunate to have in its ranks physicians who are willing to respond quickly and effectively at key moments to bring our case before the legislature. But also, we have experienced staff who are on call at the Capitol whenever the legislature is in session, who monitor all of the routine meetings of committees and other bodies, who read thousands of pages of regulations, who sift through hundreds of pieces of legislation, and who know the legislators themselves. In short, we benefit in many subtle ways from the day-to-day efforts of staff whose constant presence in the halls of government is critical to the success of our own efforts.

I don't have a crystal ball to see the final outcome of Pennsylvania's workers' compensation reform, though current signs are quite encouraging. Before the legislative recess for the primary, the Senate Labor and Industry Committee voted to replace the link to Medicare with modified use of the federal workers' compensation fee schedule. Our Quick Response Committee has been reviewing all the provisions of the amended bill in order to adjust our continuing efforts as needed. This legislation still faces more votes and possibly more revisions and amendments.

We in the Society's leadership are committed to engagement in each step of the political process, as we have been from the beginning. We cannot control the final outcome, but we can and will be untiring in our efforts to ensure that Pennsylvania's laws are working in the best interest of our patients.


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LETTERS TO THE EDITOR

"FAMILY UNITY" VIEWS DIFFER

Congratulations to Dr. Victor Greco on his excellent discussion in his article, "Family Unity: A Point of View," which appeared in the February issue of PENNSYLVANIA MEDICINE.

John H. Hodges, MD
Wynnewood

This is a brief note to second the sentiments in Dr. Victor Greco's article on "Family Unity." Having tragically lost one of our family, our son Noah, we can appreciate the value of a strong and close family even more. My wife and I were unfortunately not well-appraised of the most devastating threat to family unity today—the destructive cult. I think that should be on the top of the list of social forces threatening family unity. Overall, I cannot agree more with Dr. Greco's sentiments.

Edward A. Lottick, MD
Kingston

I am writing about the editorial, "Family Unity: A Point of View," by Victor Greco, MD. I believe that its discussion of working women does a disservice to the reasons women have careers. I also believe that "organized medicine" cannot afford to publish this without comment or objection.

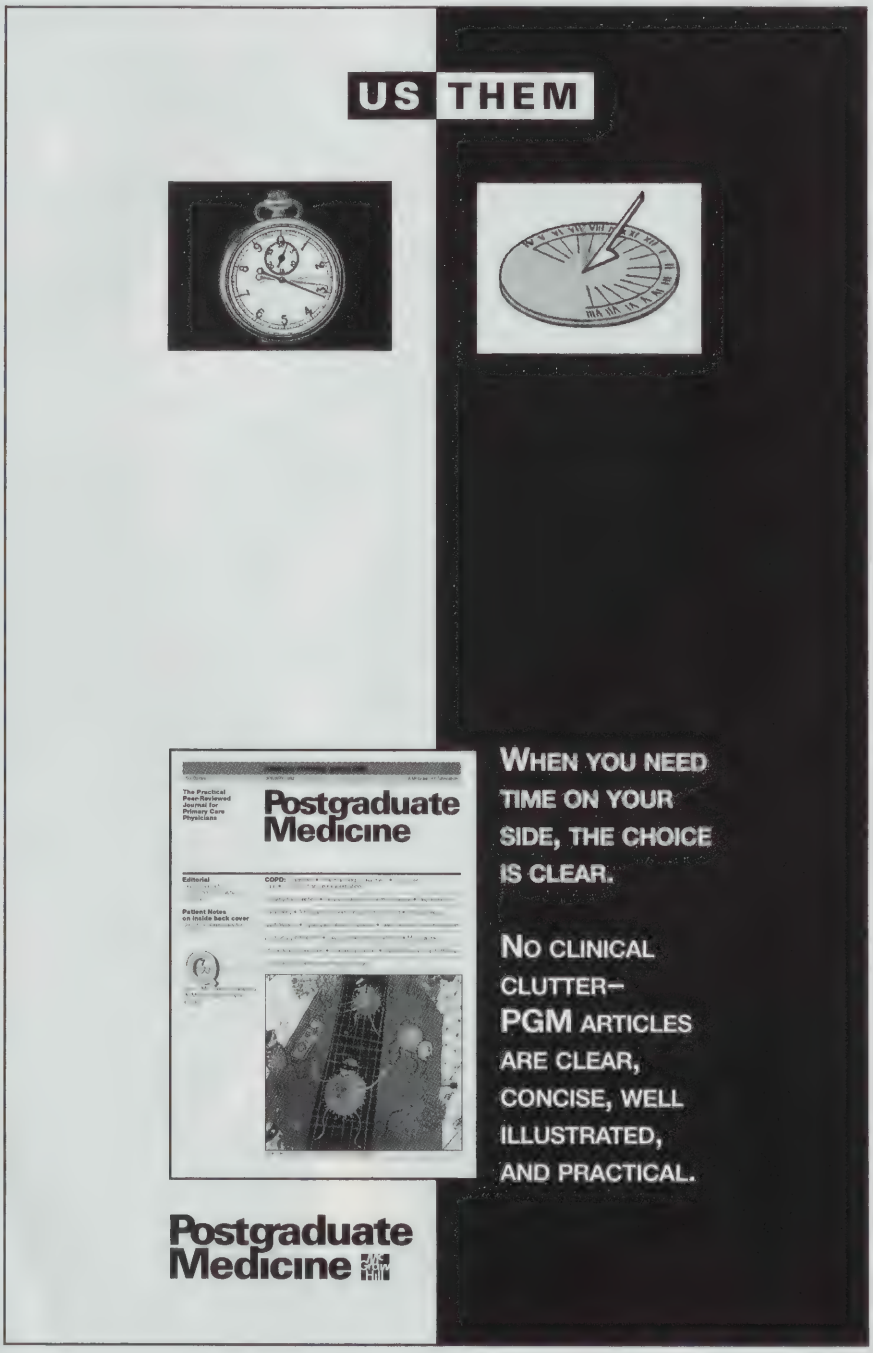
Dr. Greco's premise that family unity, strong parenting, and a resetting of priorities will positively affect society is good. However, he degrades women's careers as mere materialism, without asking for responsibility from all family members. He does not, as he says, show "due respect to the women of the country." He does not ask why men are not taking more responsibility for raising or co-parenting children. He asks us to go backwards to our grandparents' time, not forward to a better future. Strong principles of the next generation will be found looking forward, not back.

My deeper concern about this "Discharge Summary" is not Dr. Greco's opinion, but why the managing editor allowed this to be published. Articles which are slanted against women working have *no* place in our journals. If they are printed, it becomes the responsibility of the editor to find a balancing piece or to distance our medical society from this opinion. If another minority group was substituted into the paragraph about women, would PENNSYLVANIA MEDICINE have published the article?

Catherine Clarke, MD
Wynnewood

Response: Dr. Greco's "opinion piece" was published at my request, and placed on a page reserved strictly for opinions, however controversial. It is not necessary to always publish an opposing view, although we welcome such at any time. Dr. Clarke's equation of women to a minority group is surprising to me. Obviously, "Family Unity: A Point of View" was not a racial or ethnic slur; it transcends such and speaks of the loss of morality and discipline and good parenting role models. There has been a breakdown of morality in this country, and I do believe that it can be traced to the loss of the family unit. PENNSYLVANIA MEDICINE does appreciate Dr. Clarke's comments.

John W. Mills, MD
Medical Editor



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First Public Report for Physicians Due This Summer

John A. Malcolm Jr., MD

Public reporting of physician-specific information by the Pennsylvania Health Care Cost Containment Council begins this summer with the release of a report of physician-specific surgical data. Physicians should be aware that the release of such information may have a significant impact on decisions made by patients or potential patients.

"The impact of the report on health care decisions made by patients or potential patients is likely to be significant . . ."

Dr. Malcolm, a pathologist from Sunbury, is chairman of the Society's Task Force on Health Care Cost Containment and a member of the Joint Committee on Health Care Data of the State Society, the Pennsylvania Osteopathic Medical Association, and the Hospital Association of Pennsylvania.

Culminating a decision announced in December 1991, the Pennsylvania Health Care Cost Containment Council (PHC4) will publish data on coronary artery bypass graft (CABG) surgery performed at hospitals and by physicians in Pennsylvania for the calendar year 1990. The report is expected early this summer, having been slightly delayed in part for modifications sought by the Joint Committee on Health Care Data of the State Society, the Pennsylvania Osteopathic Medical Association (POMA), and the Hospital Association of Pennsylvania (HAP), as well as the State Society's Task Force on Health Care Cost Containment.

The impact of the report on health care decisions made by patients or potential patients is likely to be significant if the experiences following similar releases in New York and New Jersey are repeated. In New York, the public misconstrued the meaning of the data when it was published by newspapers without adequate explanatory text.

In an effort to avert or diminish such deleterious consequences, PHC4 is trying to make the technical aspects of predictive outcome statistics (especially mortality) follow accepted practices in current medical literature. To do this, PHC4 statisticians reviewed the predictive factors utilized in the studies reported from New York, New Jersey, and the American Society of Thoracic Surgeons (ASTS).

Eight of the top-ten recognized major predictive factors of patient outcome (mortality) were selected—using multivariate analysis (chi square methodology)—and applied to develop statistical ranges of predicted mortality to be matched against each hospital's and physician group's actual mortality figures. Predicted rates of mortality will also be matched against those developed by the ASTS for several of the same hospitals and physician groups for the same year, 1990 (identical patient base). The two methodologies and their results will be compared by a third party, the Keystone Peer Review Organization (KePRO), who will publish the results of this limited comparison.

Largely because of the problems associated with statistics derived from or applied to small numbers, the PHC4 report will not include the predicted or actual mortality and morbidity figures for individual physicians performing CABG surgery, but will include them for each hospital and physician group. PHC4 stresses that, though this first-time report is far from perfect, they feel it represents 1) an advance over reports previously released by New York and New Jersey, and 2) a significant improvement over the initial December 1991 proposal.

In the interim, since December 1991, the physician community raised a number of serious concerns. Of major concern is the use of MedisGroups™ as the major determinant methodology to predict treatment risk (mortality and morbidity) for CABG surgery patients, especially since other methodologies, designed specifically to risk-stratify patients undergoing cardiac surgery, do exist.

PHC4 developed another methodology for mortality prediction to avoid this valid criticism previously noted. However, validation of the new PHC4 methodology against other validated methodologies



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must still be done. The morbidity criticism remains, and PHC4 is currently not planning to include predicted morbidity in reports for patients operated on after the third day of hospital admission. Further resolution of the problem is being sought.

CABG surgery involves a complex array and interplay of physicians, hospital services, and personnel such as anesthesia, operating room, cardiopulmonary bypass, recovery room, intensive/critical care, cardiology, pulmonary medicine, and cardiovascular surgery. Assigning patient outcomes solely to the operating surgeon, without review and assessment of the patient's hospitalization through the medical record, appears inappropriate. The operating surgeon does not control the direct performance of all interfacing personnel and services, and infrequently controls the critical post-operative care in the recovery room, intensive/critical care units, etc.

"We must express extreme caution to the public not to inappropriately attempt to extrapolate this first and single year's data."

Significant differences noted in previous PHC4 data, between outcomes of patients undergoing CABG surgery in different hospitals utilizing the same operating physicians, also support the contention that other significant factors beyond the skill of the surgeon affect patient outcomes. PHC4 still assigns patient outcomes to the "Captain of the Ship" physician whom it recognizes as the operating surgeon—the same as is done in New York and New Jersey in their public reports on CABG surgery.

Because of the MedisGroups™ weakness of inaccurately classifying CABG surgery patients' medical status on admission (severity scores) combined with lost specificity caused by averaging of admission severity scores, accurate correlation of hospital physician groups' and physicians' results with high/low risk patients is not achievable. Severity scores will not be published in the CABG surgery reports. Only outcome data (mortality and morbidity) will be published. Despite this change, the public still will not be able to accurately ascertain which hospitals, physician groups, and physicians treat preferentially referred higher-risk patients and handle them with superior results.

We must express extreme caution to the public not to inappropriately attempt to extrapolate this first and single year's data. Comparison with subsequent years' data will help clarify patient outcome patterns with hospitals and operating physicians. The data should primarily be used by patients in talking with their physicians about CABG surgery. The consumers' guide accompanying the published data is expected to include these viewpoints.

Operative technology is steadily evolving with greater use of balloon angioplasty, laser angioplasty, and other less-invasive interventional cardiovascular and radiological procedures. As such procedures cut into the database, the year-to-year comparability of the database is diminished unless corrective measures are applied to and reported for previous years.

PHC4 is fully aware of the concerns brought by the joint committee, the task force, and others, and has modified the report to meet some of the concerns where it could, without substantially delaying its publication schedule. Council members readily acknowledge that the report is far from perfect, but stress that they feel it will be the next logical evolutionary statewide report built upon previous experiences of other states' reports on CABG surgery.

PENNSYLVANIA MEDICINE will publish a follow-up article within the next few months to give physicians a glimpse of what the finalized report of PHC4 physician-specific data will look like. The article will also include suggestions to help physicians answer questions about the data.

SENATE PANEL AMENDS WORKERS' COMP BILL

On April 6, the state Senate Labor and Industry Committee by a 9-2 vote amended House Bill 2140 to remove the proposed link of workers' compensation fees to the Medicare system. Contained in the amended bill are many provisions initiated by the State Society, including use of the federal workers' compensation fee schedule, establishment of an annual inflation adjustment, and provision of procedural safeguards.

Introduced by Senators Robert D. Robbins (R-Mercer), James C. Greenwood (R-Bucks), and Noah W. Wenger (R-Chester/Lancaster), the amendment more specifically:

- limits reimbursement of non-hospital providers to the lesser of the provider's actual charge or 80 percent of the federal Office of Workers' Compensation Programs (OWCP) maximum allowance for 1992 when multiplied by the established geographic index value;
- establishes a floor for the geographic index values of 1.70 to aid areas adversely affected by the OWCP schedule;
- provides for an adjustment on January 1, 1993, and annually thereafter, equal to the percentage change in the annual statewide average weekly wage (the average increase in the past five years equals 4.7 percent);
- creates a cost-to-charge reimbursement formula for hospital inpatient/outpatient services with an annual increase;
- reimburses comprehensive rehabilitation service providers from a modified OWCP schedule;
- requires the Secretary of Labor and Industry to periodically verify the reasonableness of fees to assure adequate numbers of qualified health care providers;
- exempts care provided in trauma facilities and burn centers from the OWCP schedule;
- excludes services—such as peer review, expert testimony, depositions, and extra reports—not required by law from fee limitations;
- sets criteria for formation and operation of coordinated care (managed care) organizations to deliver care, and excludes employers and workers' compensation insurers from owning such care organizations;
- requires use of uniform claim forms and coding, and streamlines claims submission and adjudication processes; and
- establishes standards for peer review organizations and their review of the cost and medical necessity of medical services.

Prior to passing the amended bill, the committee discussed its implications in great detail, including potential for savings, estimated at 20-25 percent. Since the legislature recessed until early May, no floor action was taken.

Though pleased with the amendment overall, the State Society still has a few concerns, especially since the federal fee schedule was discounted more deeply than anticipated. The Society's Workers' Compensation Quick Response Committee is evaluating the impact of the changes in more detail. The committee will then determine a strategy for further Society action, which is needed to achieve fair workers' compensation reform.

GOVERNOR SIGNS LIVING WILL LAW

A living will bill, which would allow most Pennsylvanians to refuse life-sustaining treatments in advance, was amended and passed by the state House of Representatives on April 7 by a vote of 188-5. The Senate then passed the bill 47-1; and Governor Robert P. Casey signed the bill into law April 17.

The passage ends at least a decade of legislative debate on the issue. The legislative chambers drew praise for their decisions from various sources, including the state's secretary of aging, Linda Rhodes. The Society, also pleased with passage, will continue its efforts to help physicians and patients with the advanced directive process.

Before passage last month, Pennsylvania was only one of two states in the nation without living will legislation. The measure was originally passed by the Senate last year, but controversies over how to handle exclusions for pregnant women and several other issues stalled the bill in the House. Little debate occurred on the amended language, which significantly revises Pennsylvania's guardianship laws.

SOCIETY SEEKS HELP IN SECURING CO-SPONSORS

In late March, the State Society asked physicians serving as "federal key contacts" to request assistance in securing co-sponsors for two new bills, House Bill 4507 and Senate Bill 2362. These bills:

- act to repeal the Medicare payment differentials which currently exist for new physicians during their first four years of involvement in the Medicare program;
- contain budget neutrality language which conforms to the "pay-as-you-go" provisions in the 1990 budget agreement; and
- direct the Secretary of Health and Human Services to make reductions in the aggregate Medicare payments, pursuant to physicians' payment schedules, to offset increased spending.

The present law discriminates against young physicians and those new to the Medicare program by forcing them to be paid 5-20 percent less during their first four years of practice than established Medicare service-providing physicians, and violates the concept adopted by Congress against delivery of Medicare payment differentials on the basis of resource costs.

No data indicate that physicians new to the Medicare system experience lower resource costs than those in established practices. In fact, due to educational loans and start-up costs, the opposite may be true. In addition, the law may discourage new physicians from seeking training in lower-paying specialties with high Medicare patient populations. Both the AMA and the State Society strongly oppose discrimination in reimbursement practices based on age or years in practice.

CASEY OFFERS HEALTH CARE BILL OF RIGHTS

Governor Robert P. Casey has outlined legislation that would protect health insurance policyholders from unfair practices by insurance companies.

The proposed Health Care Consumer Bill of Rights, revealed March 30, would prohibit insurance companies from cancelling group or individual health policies unless the premium was not paid or if fraudulent information was given on the application. The bill also proposes several other provisions, including providing health insurance protection for employers who change group insurance policies and for individuals who change jobs.

NEW HCFA 1500 FORM IN USE

Physicians must now use the new 1500 (12-90) claim form of the Health Care Financing Administration (HCFA). The new form, effective for claims *received* by Medicare on or after May 1, 1992, replaces the HCFA 1500 (1-84) claim form and must be used for both assigned and non-assigned claims.

The new form is printed in red ink to accomodate optical character recognition. It is available in various forms (e.g., single copy, duplicate) and can be obtained from the U.S. Government Printing Office (202-783-3238) and the AMA (800-621-8335).

In the past few weeks, Medicare has held a number of "how-to" training seminars for office assistants throughout Pennsylvania on completing the form. The *Medicare Special Bulletin* mailed on March 6, 1992, also decribes in some detail how to complete the new HCFA 1500 form.

Blue Shield private business will accept the new form but will continue to accept the HCFA 1500 (1-84) edition as well as their own HCFA 1500A and HCFA 1500AC editions. However, since all Medicare changes—such as place of service codes—do *not* correspond to private business reporting requirements, physicians must use a special instruction sheet to correctly complete the form for Blue Shield. Note also that while Blue Shield will *not* provide either the new form or the 1500 (1-84) edition free-of-charge, the carrier will continue to provide the HCFA 1500A and 1500 AC forms free-of-charge.

In addition to requiring use of the new claim form, Medicare is prohibiting the use of "superbills," effective for claims *received* on or after May 1, 1992. Superbills have been defined as attachments which are used by physicians in lieu of entering required information in the appropriate areas of the HCFA 1500 (12-90) claim form. Non-standard claims received after April 30, 1992, will be returned for proper completion. Other attachments (i.e., certificates of medical neccessity) and medical records are not affected by this new policy, and Blue Shield will continue to accept superbills for private business.

HCFA CORRECTING PAYMENTS ON 40 CPT CODES

The Health Care Financing Administration (HCFA) has instructed its carriers to establish adjusted historical payment bases (AHPBs) for approximately 40 Current Procedural Technology (CPT) codes new in 1991 or 1992. They discovered the transition rules were incorrrectly applied when the 1992 payment amounts were calculated.

In general, because their AHPBs were set at zero, these codes went immediately to the full resource based relative value scale (RBRVS) payment schedule with no transition. HCFA is now providing "crosswalks" to old codes to be used by carriers in establishing AHPBs. This will often result in new 1992 payment amounts for these procedures.

In addition, relative value units for approximately 150 technical component codes and the related global codes will be changed as a result of a new methodology to calculate technical components. Carriers were expected to issue a bulletin notifying providers of the new payment amounts and charge limits by April 30, 1992.

Please note: Carriers have been instructed to *re-open* any claims for services submitted after December 31, 1991, *which are brought to their attention for correction*. This means carriers must not automatically make up for underpayments to physicians. Therefore, physicians should carefully review new payment amounts to see if any additional payments are due.

SELECT E/M CODES REVISED SIGNIFICANTLY

After release of resource based relative value scale (RBRVS) fee schedule amounts in early December 1991, the State Society received a number of calls from physicians questioning why their fee schedule amounts for evaluation and management (E/M) services were lower than anticipated. As a result of these inquiries, the Society obtained E/M code adjusted historial payment base (AHPB) data for all four localities of the state, as well as 1991 prevailing charge data for the five specialities which have the highest frequency billing of E/M codes.

Based upon a Society analysis of the compiled data, Pennsylvania Blue Shield, the state's Medicare carrier, advised the Society that a mistake had been made in the calculation of the confirmatory consultation code 99274. Payment increases resulting from the correction are significant and include:

Locality	Old Payment	New Payment
Area 1	$52.81	$100.39
Area 2	55.73	99.16
Area 3	62.53	94.07
Area 4	52.47	92.98

Pennsylvania Blue Shield will automatically reprocess all claims previously processed incorrectly and pay the difference between the old and new rates. The State Society will continue to review AHPB calculations to determine if other mistakes have been made.

PAYMENT ERROR FOUND TO NEW PHYSICIANS

Medicare has incorrectly paid, in some instances, physicians subject to new physician reductions. The payment problem was a result of a rounding error.

The fee schedule amounts for new physicians are calculated to the third decimal point. In those cases where the third decimal point is five or higher, Blue Shield is required to round up when calculating the payment due. However, Blue Shield initially failed to do so as required, resulting in underpayments of one cent.

The incorrect payments only occurred when a new physician was involved, the third digit past the decimal point was above five, and the service was reduced under the new physician rules. For example, a primary care service would not have been affected since such services are not reduced under the new physician rules.

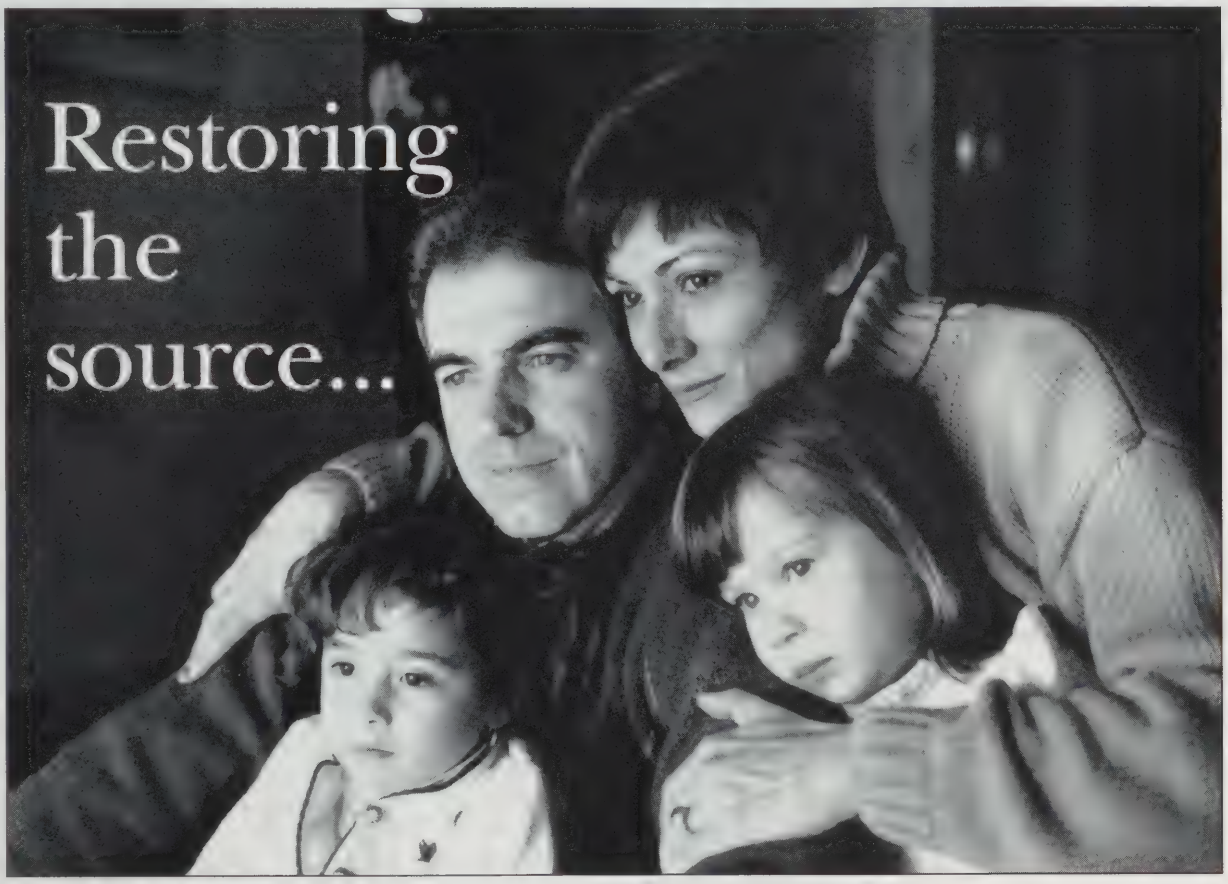
After the Society brought the

problem to Blue Shield's attention in early March, the carrier immediately took steps to correct the problem for future payments. Since it is unlikely that any physician was affected by more than $1 in total underpayments, Blue Shield does *not* intend to automatically make retroactive payments for previous underpayments. However, it will do so upon the request of an individual physician.

Dennis L. Olmstead, the State Society's director of medical economics, contributed to this page.

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Health Views from the Senate

Maria T. Montesano
Assistant Managing Editor

The state legislature is comprised of a mixture of personalities and viewpoints. In this first of a series of three interviews with members of the general assembly, Senators John Peterson and J. Doyle Corman talk about life in rural Pennsylvania, what physicians can do to be more involved in the political process, and a number of other issues.

Question: *Senator Peterson, as chairman of the Senate Public Health and Welfare Committee you have been interested in legislation to enhance rural health care. What are your views on that?*

Senator Peterson: While a national health care debate is going on about access and affordability, a serious access crisis is developing in rural Pennsylvania and in rural America...Medicaid was not a big factor in rural Pennsylvania 20 years ago, but today there are rural counties with large numbers of Medicaid patients, and most of rural America is aging...So, you have a population heavily loaded with Medicare, and with the growing Medicaid population, it's certainly not attractive to new, young doctors...Most of my rural hospitals are struggling to recruit primary care physicians, and certainly the areas that are thin on physicians overall will have a hard time attracting the family physician, the internist, the pediatrician, the OB/GYN...There are serious problems already out there and unless we change federal and state reimbursement policies, unless we go back to primary care as the major initiative, rural Pennsylvania will have serious access problems.

Question: *Senator Corman, you have an interesting situation in that you are from a generally rural area, but one that includes the populated main campus of The Pennsylvania State University. The Milton S. Hershey Medical Center is part of Penn State. Is there anything that a facility like the Medical Center can do, because of its tie, to help the rural areas?*

Senator Corman: They could help train physician assistants and nurse practitioners that might augment what doctors are doing. Geisinger Medical Center uses [physician assistants] in their facility. Unless you specifically ask for the doctor, many times you get a doctor's assistant. We are probably going to need—particularly in the more peripheral part of my district—more of those kinds of people, and Hershey could help train them.

Senator Peterson: Also, Hershey has a primary care initiative which should be duplicated at both Pitt and Temple...[All three] are state related and receive large amounts of state funding...There ought to be some strings attached [one of which would be] producing more primary care physicians.

Question: *To shift gears a little bit, two of the six Senate votes against the "MOM" bill [which prohibits physicians from charging a Medicare patient more than the Medicare reasonable charge] are sitting here. It must have been a difficult vote for both of you. What was the rationale behind your votes?*

Senator Corman: Mine was an angry vote...I had to leave the floor for something, came back after I knew the decision, and still voted no...I agree very much with John in our discussion of it...I felt it might *cost* rural people accessibility to the doctor's office if the doctors' fees were in fact going to be cut so harshly...maybe the availability of the doctors wouldn't be there. Also, I just didn't think it was fair...it seems to me that part of what makes America great is that we all pitch in, and those who could afford to pay the full fees certainly should have to, in my judgment.

Senator Peterson: I think the whole bill is predicated on a false assumption

This interview was conducted by Miss Montesano, in cooperation with the State Society's Department of Governmental Affairs Division of Legislative Affairs, Larry L. Light, director.

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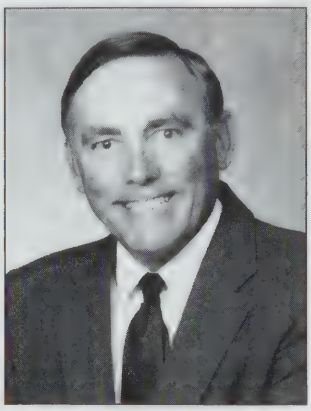
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SENATOR J. DOYLE CORMAN

Senator Corman is a Republican representing Pennsylvania's 34th District, including: Cameron, Center, Clinton, and Mifflin counties, as well as parts of Clearfield and Juniata counties. He is currently serving his fifth term in the Senate and is chairman of the Transportation Committee, vice chairman of the Banking and Insurance Committee, and a member of several other committees, including Public Health and Welfare, and Approriations.

that Medicare rates are fair and that Medicare is evenly distributed around the Commonwealth. [In reality,] from neighborhood to neighborhood, and urban to rural communities, there can be a 50-60 percent differential on what doctors receive under Medicare through the complicated formula that they [the federal Medicare program] use, and I don't know what's fair about that...You're not going to attract doctors to government when 70 or 80 percent of the business is [run by the] government: slow pay, difficult paperwork...It's already driving doctors out of rural areas...I just never felt it was fair that anyone, no matter what their value or worth, could get a Medicare fee that is a fair fee...In my view, the bill was inappropriate.

Question: *Senate Bill 1034, which is currently tabled, removes the requirement that the state secretary of health be a physician. Would you like to comment on the issue?*

Senator Peterson: That bill passed out of this committee [Public Health and Welfare] with my support last session and again this session. I know that the Medical Society is not excited about it, but it was interesting...The [Society's] one concern that I wasn't aware of at the beginning was that the secretary of health also sits on every medical licensing board at the Department of State. I understand that now. We have a physician general bill that we're going to be putting out very soon. The physician general will be more like the surgeon general, whose role will be to act as a health advocate for the state. We are considering putting an amendment in that bill that if the secretary of health *might not* be a doctor, then the physician general, if the bill became law, would serve on all of the licensing boards in lieu of the secretary of health...Also, it seems the problem is the [state's] inability to hire a highly qualified physician who has the administrative skills collectively and *wants* to be the secretary of health.

Senator Corman: In the past I pretty much felt the same way as John: though we've had some good ones, most of the secretaries of health have been pretty weak, and the idea of expecting a doctor to give up a good practice to come here to be secretary of health is something that probably wouldn't happen. That was my position until I have spoke to the Centre County Medical Society. They believe strongly that the secretary ought to be a doctor. They told me the Pennsylvania Medical Society offered their services to the governor to search out a doctor to be the secretary and their offers were not accepted. They said they could supply any number of doctors who may be willing to polish off their career and be the secretary of health, and be a good one. And so, I've somewhat slipped in my strong position that the person need not be a doctor...If there are doctors available who are administrators, I have no problem with that...In all practicality, maybe the law ought to say that the secretary should be a doctor *if possible*.

Question: *What do you think is the most significant medical issue facing Pennsylvania today?*

Senator Corman: It seems to be affordability and availability of medical insurance...[and I mean] affordability and availability so that an individual can afford to use the good practitioners who are out there...Medical insurance is becoming one of the biggest expenses businessmen have—providing group insurance for employees. And if the businessman decides insurance is not affordable, how do these people get insurance? I think there's a vast number of people that don't have it and maybe, even more than that, won't have it as it becomes more expensive... Many things have to happen, and medical liability reform is a part of that.

Senator Peterson: I think the greatest threat facing the medical community in this country and in Pennsylvania is that the media and a chorus of others are tearing down our system. Health care is on almost every news program, and I think journalists are, maybe successfully, convincing the public that we have an awful system. I'm here to tell the world, "We have the best health care system in the world." I'm not saying we don't have some real cost problems which need to be dealt with, but I don't think there's any place anybody would rather be if they're ill than in the United States.

Question: *What is your view on how physicians can best be involved in the political process?*

Senator Peterson: I represent a large, ten-county district, and I probably can count on one hand the doctors that play a real role in the election process...there are

not many. I understand they're practicing in very high-tech, skilled positions, but I tell them all pretty bluntly, "The squeaky wheel gets the grease. Don't expect us to understand all of your problems if you're not communicating them." I'm going to say this, and I say it to every group, "I always check with the folks back home." I don't just take the advice of the state or the national association as gospel, because I find out, no different than the state government, the urban influence on associations is great...[and] the perspective I represent is rural....

[Physicians] need to become a lot more involved in the process, and personally, I get my best advice from folks who are providing a service or running a business back home, who are dealing with the state and federal government and sometimes the monster that it can be. They give me the best evidence of why I should or shouldn't do something. Every county ought to have people who periodically, on an on-going basis, have a cup of coffee with their legislators. Not just when there's a problem, not just when there's a crisis, but on an on-going basis. I think doctors fail the test of being good participants in the electoral process.

Senator Corman: Since we're both from a rural area, our answers are probably going to be very similar...I found what John was just saying to be very true...there is a more urban flavor to most all of our organizations, so I too like to call back home and talk to the farmer, the doctor, the dentist and find out: "Do they agree with what their association is promoting in Harrisburg, and where should I be on this particular issue?" In fact, one of the individuals I speak to frequently is Dr. Larry Denney. He's been actively involved in my political fundraising. Dr. Ed Dench, too. He's someone I talk with about medical issues. But they are the exception, rather than the rule...I find that doctors seem to be very busy, and I understand that. I know when I'm calling my doctor...if she's not available, I get disappointed. So I understand they're busy; but *if* they want to have an impact in politics, they need to find time among them to sit down in a small meeting to discuss the issues... Thinking about all the physicians in my six counties, I have to say that their participation has been very small...Our job is to hear both sides of an issue and try to make a decision that's proper for *all* the people in Pennsylvania; and if your side isn't getting told, then it doesn't even get into the thinking process.



SENATOR JOHN E. PETERSON

Senator Peterson is a Republican representing Pennsylvania's 25th District, including: Elk, Forest, McKean, Potter, and Warren counties, as well as parts of Clarion, Erie, and Venango counties. He served two terms in the state House of Representatives, is currently serving his second term in the Senate, and is up for re-election this year. Senator Peterson is chairman of the Public Health and Welfare Committee, vice chairman of the Community and Economic Development Committee, and a member of several other committees, including Appropriations.

NEXT MONTH

Look for an interview with Senator Michael M. Dawida.

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Lobbying: The Best Kind Can Be Self-Taught

Carol E. Rose, MD

The Pennsylvania Medical Society pays professional staff to lobby for its members, as do almost all specialty groups in each state and in Washington, DC. Paid lobbyists have specific legislative responsibilities, but their efforts cannot be the only ones put forth on behalf of physician interests.

For additional information about becoming a member of the Pennsylvania Medical Society's Legislative Action Team, call the Society's Department of Governmental Relations at 1-800-228-7823.

Not many years ago, if you had quoted me as saying, "I'm not a political person," you would have been accurate. So what am I doing now as an active member of governmental relations entities of the State Society? You might say that I'm a "volunteer lobbyist"—something all physicians should consider becoming.

The State Society represents 21,000 physicians of diverse specialties and opinions. I believe the Society's paid lobbyists do a good job, but they need the backup from physicians who live in legislators' districts. Legislators know that lobbyists are paid to express a "corporate" opinion, yet legislators depend upon constituents. They want your vote as well as your personal or political action committee (PAC) contribution to campaign funds. Quite frankly, you have much more "grassroots" political clout than our very knowledgeable lobbyists. In addition, with all the issues concerning medicine today, it is very difficult for a few lobbyists to cover all the issues with 50 state senators and 203 state representatives...and do it well enough to accomplish all our goals.

So now you are probably thinking, "But I don't know how to use my clout," and you may be just as adamant as I was that you are not a political person. Well, you really don't need to be political. Instead, you must admit to yourself that you are not pleased with all the happenings in the political arena, and you must be willing to "learn a few tricks" to become an effective volunteer lobbyist. Here are a few facts to help you:

- Legislators are plain people, like you and me, who want to be liked and admired by their constituents.
- Most legislators are not so overly impressed with themselves that they are aloof and unapproachable. In fact, it is rather easy to get an appointment. When the Pennsylvania legislature is in session, most legislators are in Harrisburg Monday through Wednesday and available in their home offices on Thursday and Friday. To make an appointment, call either the local or Harrisburg office and ask for the appointments secretary. If you wish to visit in Harrisburg, even if the legislature is in session, your senator or representative can frequently leave a meeting, caucus, or hearing to keep an appointment.
- If you have an opinion about an issue but don't know who to contact, call the State Society at 1-800-228-7823. Ask to speak to a Governmental Relations staff member who can tell you which legislator to contact and where. Don't feel uncomfortable if you don't know who your legislator is—it is a very common occurrence.
- Legislators are not experts on every piece of legislation in process. They have staff assistants who do a lot of background research for them, and both the legislators and their assistants are interested and open-minded about being educated on issues. Sometimes talking with the staff assistant is just as valuable as talking with the legislator. If you come across an interesting journal article or newspaper clipping that expresses your opinion on an issue, perhaps better than you could have, send a copy of the piece with a short personal note to the legislator.
- Letters are a genuine tool of volunteer lobbyists. You needn't be formal with your letter writing: a short, legible, handwritten note is perfectly acceptable. Also, remember that no elected official could possibly respond to each individual letter in detail; and though you may receive a form letter response which may not address the exact issues raised in your letter, be assured that your point is being considered.

Dr. Rose, Pittsburgh anesthesiologist, is a member of the State Society's Council on Governmental Relations and chairman of its Subcommittee on Legislative Action Teams.

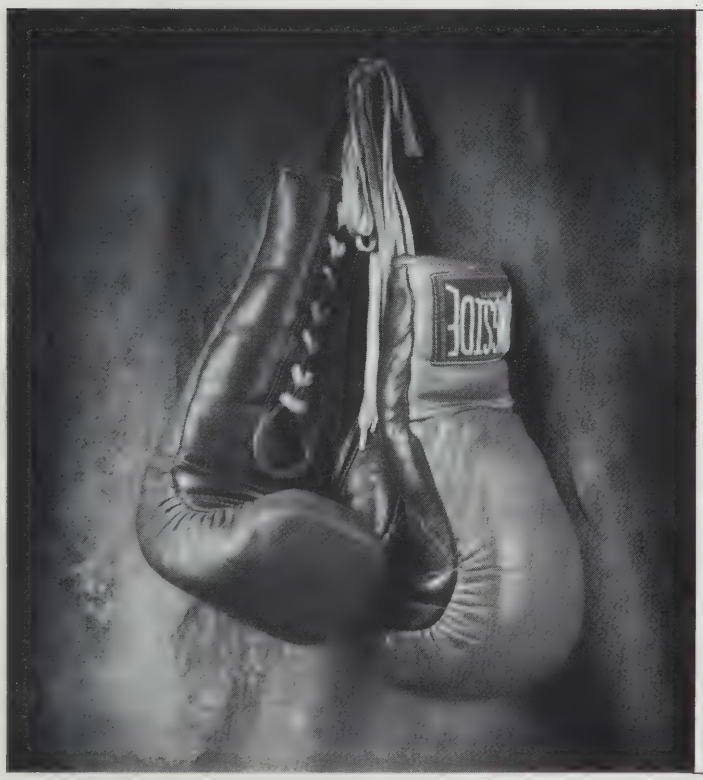
• Many legislators send out surveys to their constituents. These surveys are read. Don't be afraid to sign your name to the survey and identify yourself as a physician if appropriate.

• When the State Society organizes a "rally" in Harrisburg, try to participate. These events are well-organized and often very interesting. All you have to do is find out the day's schedule from the Society announcement, call your legislators' Harrisburg offices for appointments, and explain that you will be at the Capitol for an organized purpose. Then, show up at the right time and place, and follow directions. Often you will be asked to attend a debriefing by Society staff before you return home, so they can evaluate the effectiveness of the rally. If you cannot attend the rally, consider calling your legislator to relay your opinion. Either in person or by phone, you may be surprised at the pleasant reception.

• Attend town meetings and speak up. These meetings, which are held in your home district, give your legislator the opportunity to field opinions on many issues. They are also frequently held in conjunction with the election cycle. Your legislator wants to make a positive impact on constituents—use that to your advantage. The more your legislator listens, the better he or she will look. Also, approach your legislator before or after the meeting to make sure your identity is perfectly clear.

• Join a Legislative Action Team (LAT) of the Society. As a LAT member, you will receive CALL TO ACTION letters requesting your lobbying efforts. Letters will include information about who to contact and what salient points should be emphasized.

Becoming an effective contact takes time. You won't become fully "certified" on your first attempt, but your comfort level will increase as time passes and as you see the positive results of your activities. Then, before you know it, you'll realize that you have gradually become a *volunteer lobbyist*.



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Understanding CLIA '88

Robert J. Lilley

New regulations under the Clinical Laboratory Improvement Act of 1988 have been finalized, but not without objection from the State Society. This article outlines the regulations, compares them to those originally proposed in May 1990, presents a compliance timeline, and touches upon Society concerns.

Regulations ultimately affecting some 130,000 physicians' office laboratories nationwide became final on February 28 this year when the Health Care Financing Administration (HCFA) published its rule implementing the Clinical Laboratory Improvement Act of 1988 (CLIA '88). HCFA will begin billing for initial registration in May.

While the regulations are improved over those first issued in 1990—in large part due to the avalanche of more than 60,000 comments from physicians and medical organizations—they may initially require Pennsylvania laboratories to operate under a "dual" system. In the Commonwealth, current law regulates all physician laboratories; while the new regulations allow for such state and nonprofit programs to be exempted, an indeterminate delay will occur in publishing procedures to request exemption from CLIA's rules. Pending resolution of this situation, both federal and state regulations may apply.

The Society has voiced its objection in a strongly worded letter to HCFA and requested at least a temporary exemption for Pennsylvania. Other comments from a task force of four Society physicians were also included in the letter.

Categories of laboratories

The new regulations establish three categories or levels of laboratories, generally distinguished by the complexity of the tests they conduct. These include waived tests, tests of moderate complexity, and tests of high complexity. There have been considerable changes *within* each level from the original regulations of May 1990.

Waived tests are simple laboratory examinations and procedures which: 1) are cleared by the Food and Drug Administration for home use, 2) employ methodologies that are so simple and accurate that they render the likelihood of erroneous results negligible, or 3) pose no reasonable risk of harm to the patient if the test is performed incorrectly. Laboratories which conduct waived tests must limit themselves to the following eight tests: dipstick/tablet urinalysis, ovulation tests, urine pregnancy tests, nonautomated erythrocyte sedimentation rates, hemoglobin (copper sulfate), fecal occult blood, spun microhematocrit, and blood glucose monitoring.

Such a limit represents a significant reduction in the number of tests previously proposed, as well as currently included, in the state's lowest category; and it may prompt involuntarily upgrading presently registered but unregulated physician office laboratories to the next level. However, the AMA believes this new approach is far more reasonable and more accurately reflects the reality of medical practice testing patterns in such laboratories.

The biennial fee for waived test labs is $100. The state currently imposes no charge for its lowest level laboratories. Laboratories which conduct only waived tests are essentially exempt from CLIA '88 requirements and need not participate in proficiency testing or meet personnel or quality control standards. They must, however, follow manufacturers' instructions for tests given and will be subject to unannounced inspections. Both the AMA and the State Society have vigorously protested unannounced inspections due to the potentially disruptive effect on the office operation and patient care.

The next level is for laboratories which conduct tests of moderate complexity. Approximately 75 percent of all test procedures will fall in this category, which has been considerably expanded. And the third and highest level is for laboratories which perform tests of high complexity—in other words, all other tests. The biennial registration fee for both moderate and high complexity laboratories depends upon the number of tests performed annually and the scope of tests involved. The fee could range from $100-$600, but the Society believes the vast majority of physician laboratories will be assessed the minimum $100 fee.

Mr. Lilley is the State Society's assistant director of educational and scientific affairs.

Standards

Unlike laboratories conducting waived tests, moderate and high complexity laboratories will be subject to several general standards as described below. In general, they will differ for each level only by degree.

Personnel: Personnel standards have been significantly relaxed from the original version, which almost required a pathologist to serve as a laboratory director. Now, any physician currently operating a laboratory should be able to serve as the laboratory director, technical consultant, and/or clinical consultant. For moderate complexity laboratories, testing personnel need a high school diploma and appropriate training. For high complexity laboratories, testing personnel will need to earn an associate's degree in an appropriate scientific discipline by September 1997.

Proficiency testing: All moderate and high complexity laboratories must participate in an approved proficiency testing program. They will have until January 1, 1994, to enroll in a proficiency testing program, but will not be penalized for unsuccessful participation until 1995. HCFA estimates that the annual cost of proficiency testing for physician office labs will be approximately $900.

Quality control: Each moderate and high complexity laboratory must have written quality control procedures for each analytic testing process. Laboratories must have a procedure manual, perform calibration at least every six months, and perform quality control each day the test system is used.

Patient test management: Each laboratory must employ and maintain a system that provides for proper patient preparation; proper specimen collection, identification, preservation, transportation, and processing; and accurate result reporting. This system must assure optimum patient specimen integrity and positive identification throughout, and records must be maintained for five years.

Quality assurance: Each laboratory must establish and follow written policies and procedures for a comprehensive quality assurance program, which is designed to monitor and evaluate the on-going and overall quality of the total testing process. The program must:

- evaluate the effectiveness of policies and procedures;
- identify and correct problems;
- assure accurate, reliable, and prompt reporting of test results; and
- assure the adequacy and competency of the staff.

As necessary, the laboratory must revise policies and procedures based upon the results of those evaluations. All quality assurance activities must be documented.

Inspections

Inspections of moderate and high complexity laboratories will occur once every two years. Inspection fees will vary with the scope and volume of testing, and range from $300 for laboratories doing fewer than 2,000 tests annually to over $3,000 for laboratories doing more than one million tests annually. Again, the Society expects most physician office laboratories to remain at the lower end of this scale.

Society staff will continue to monitor development of the laboratory regulations, including the status of state or third-party exemption which could modify outlined procedures. Look for updated information in the Society's publications.

"They may initially require Pennsylvania laboratories to operate under a 'dual' system."

Compliance timeline

The following are key dates and actions for compliance with the CLIA '88 regulations:

Date	Event
November 1991 to present	Survey forms returned to HCFA
May 1992	HCFA mails registration bills
July 1992	Initial registration fees due to HCFA
July 1992	Pennsylvania Department of Health mails its registration bills
July-August 1992	HCFA mails inspection bills
September 1992	CLIA standards must be in effect; inspections begin
January 1994	Proficiency testing begins
January 1995	Sanctions for failing proficiency testing implemented
September 1997	Technicians in high complexity laboratories must have completed associate's degree

SEASON FOR SALMONELLA PRECAUTIONS CONTINUES

With the Easter season just passed and summer in the air, Pennsylvania physicians must realize the health risks of Salmonella infections. These may manifest as various clinical entities, including gastroenteritis, enteric fevers, typhoid fever, bacteremia, and localized infections such as abscess and cellulitis. While the nomenclature of Salmonella is unsettled regarding speciation, there are over 2,000 recognizable serological types based on the organism's "O" somatic and "H" capsular antigens. In practice, Salmonella isolates are often serotyped and named based on a modified Kauffman-White scheme of serological identification using the "OH" and flagellar antigens.

While these facts have only tangential relevance for clinical practice, serotyping of Salmonella is important for the epidemiology and control of salmonellosis. In fact, all isolates of Salmonella should be sent to the State Laboratory for typing. Some laboratories, particularly those outside of Pennsylvania, do not forward isolates to the State Laboratory, making epidemiological follow-up of some cases more difficult.

Health departments and the Centers for Disease Control are concerned that most Salmonella gastroenteritis cases are not reported to health agencies. Those that are reported are more likely to be hospitalized or seriously ill cases, or cases sharing a recognized common source of illness (e.g. banquet, party). Adequate control of Salmonella infection is extremely difficult when only those cases representing the tip of the iceberg are recognized and reported. However, some control measures focused on specific modes of transmission can be effective.

Foodborne salmonellosis

Of 2,825 cases of salmonellosis reported in Pennsylvania during 1990, approximately 40 percent (1,184) were *Salmonella enteritidis*. Raw eggs or food products containing undercooked eggs are a common source of the disease and are frequently implicated in common source outbreaks of Salmonella gastroenteritis in a number of settings (e.g. private parties, restaurants, schools, and nursing homes).

Salmonella contamination of eggs was previously limited to cracked eggs. More recently, Salmonella have developed the ability to enter the egg while forming or through the intact shell. Therefore, refrigeration is a current requirement—colder temperatures retard the multiplication of Salmonella within the egg. Recent guidelines strongly recommend the use of pasteurized eggs in some settings. This use is important in nursing homes and hospitals where age or underlying medical conditions may predispose patients to severe outcomes from Salmonella infections. When controls fail and human disease is associated with eggs, a trace-back procedure exists that allows identification of the infected flock and appropriate control measures by the Department of Agriculture.

Not all *Salmonella enteritidis* gastroenteritis is egg associated. Other sources of this organism include raw or undercooked poultry and meat, as well as other food products. Additionally, infected food handlers with diarrhea and poor sanitation practices have been the source of some outbreaks.

Many other types of Salmonella can cause foodborne gastroenteritis. For instance, in 1990 *Salmonella typhimurium* accounted for approximately 20 percent of reported Pennsylvania cases. When foodborne gastroenteritis is caused by a less frequently isolated subtype of Salmonella, the epidemiological investigation is more likely to identify the source of the infection. Perhaps the most publicized example is the recent occurrence of *Salmonella poona* infections associated with contaminated cantaloupes.

Animal-to-human transmission

Salmonella gastroenteritis peaks during June to August. This peak is believed to be partially due to summer picnics and multiplication of Salmonella in unrefrigerated food in warm weather. Also, an unrelated, small, pre-season peak in April and May has recently been noted in Pennsylvania. This peak has been largely attributed to Salmonella infections related to infected Easter pets.

Salmonella-infected ducklings and chicks have the potential to transmit Salmonella to humans, particularly children who often have poor sanitation habits. During April 1-May 15, 1991, 22 cases of *Salmonella hadar* (group C2) infection in Pennsylvania, Maryland, and Connecticut were associated with pet ducklings hatched and sold by a Pennsylvania producer. Ages of cases ranged from three months to 42 years, with approximately 60 percent (13/22) of the cases in children under 10 years of age. The Department of Health discourages the purchase of chicks or ducks as household pets at any time of the year. These animals should never be allowed to be loose inside the home or handled unless the most stringent sanitation precautions are exercised.

However, the problem of salmonellosis associated with animal contact is not limited to Easter pets. Pet lizards, snakes, and turtles infected with Salmonella are potential sources of human infections. Though less-likely, dogs and cats are considered potential sources as well. Therefore, the clinical history of salmonellosis in children should include questions related to recent animal contact, and cases related to animal transmission should be expeditiously reported to the Department of Health.

Robert A. Houseknecht, MPH, PhD
Pennsylvania Department of Health

COMMISSION SEEKING PHYSICIAN INVOLVEMENT

Now that the Commonwealth has increased funds to its Healthy Beginnings Program, the State Society's Commission on Public Health will seek to increase physician involvement in the program. This and other issues were addressed during the commission's recent meeting in Harrisburg.

The Healthy Beginnings Program is run by the state Department of Public Welfare (DPW) and was initiated in 1988. It provides prenatal and preventative health care to low-income pregnant women and their children who otherwise would have no health insurance. Though DPW has proposed $7.2 million in state funds to expand eligibility during the next fiscal year, program success also depends upon volunteerism of practicing and retired physicians from across the state. Commission members agreed that added effort

from the Commonwealth should be met with added effort by Pennsylvania physicians, and the commission will work for increased physician involvement.

In response to two 1991 House of Delegates' resolutions, the commission also investigated the availability of insurance and retraining programs for HIV-infected physicians. Findings indicate that two insurance programs currently exist. The first is through the State Society's member benefit policy, which provides disability payments to HIV-infected physicians when they can no longer practice medicine due to the illness.

The second program, run by the American Medical Association (AMA), is a fixed-amount policy. Benefits range to $500,000, depending on the premium physicians choose to pay, and payment is received in one lump sum after a confirmed positive HIV test. The Pennsylvania Medical Society Liability Insurance Company (PMSLIC) is currently conducting a study to determine if additional programs are needed and marketable.

As for retraining programs, the commission determined, through careful study, that effective programs should be developed on an individual basis for each physician and specialty. Until follow-up is addressed by the 1992 House of Delegates in October, the commission will support the tailored approach used by the Physicians' Health Programs of the Society's Educational and Scientific Trust by referring physicians to that program, already in existence.

At its next meeting, to be held this summer, the Commission on Public Health will address Society actions toward national health promotion and disease prevention goals set forth by President Robert N. Moyers, MD, in his inauguration address.

SOCIETIES CO-SPONSORING ANIMAL RESEARCH WORKSHOP

The AMA, the State Society, and the Pennsylvania Society for Biomedical Research (PSBR) will co-sponsor a one-day workshop addressing the importance of animals to medical research. Set for May 18 at the Hershey Lodge and Convention Center, the workshop's overall goal is to encourage practicing physicians to speak out on the issue, and to build grassroots support for the use of animals in research. For further information about registration and credits, or to pre-register, call the AMA at 1-800-AMA-3211. Proof of identification and affiliation will be required for all participants.

CDC REPORTS RISE IN TB MORBIDITY

The number of tuberculosis (TB) cases reported to the Centers for Disease Control (CDC) has been increasing since 1988, after a long historic decline. In 1990, 25,701 cases were reported, an increase of 9.4 percent over the 1989 figure and the largest annual increase since 1953.

From 1985 to 1990, reported cases increased by 15.8 percent. Disproportionately greater increases in reported cases occurred among Hispanics, non-Hispanic blacks, and Asians/Pacific Islanders. In contrast, decreases were observed among non-Hispanic whites and American Indians/Alaskan natives.

By age, the largest increase in reported cases occurred in the 25- to 44-year age group; this increase may be largely attributable to rising numbers of TB cases among persons with HIV infection or AIDS. Notable increases also occurred among children.

Excerpted from
"Morbidity and Mortality
Weekly Report"
(Vol. 40, No. SS-3)
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Computer Technology, Patients, and Modern Medicine

Leo Uzych, JD, MPH

The development of computer-based information systems may prove advantageous to physicians for a number of reasons, but monitoring its evolution is essential to continued quality of care.

At a time when computer technology is progressing rapidly, health care costs are rising, and public education about health-related matters is needed, it would be unwise to simply ignore the vast possibilities of computerized services. People need information to learn about self-care and prevention, to stay healthy, and to visit their physician promptly when a problem arises. The on-line access to medical information provided by computerized services may help meet this need.

Even after a health problem develops, self-care instructions may enable a patient to manage the problem at home, while under the supervision of a physician. When sensitive topics are involved, such as reporting sexual histories, patients may feel more comfortable reporting this information by computer rather than in face-to-face interviews. A computerized communication system may also function as a major cost containment force if it provides educational information which, in fact, helps patients recognize health problems before they become serious and costly.

For physicians, the availability of medical records "on line" may have widespread, beneficial applications to clinical care and practice management:

- Prescriptions and laboratory results might be transmitted.
- Patient records could be available immediately to all physicians in a group practice setting.
- The use of automated processes in place of manual processes could increase practice efficiency.
- Knowledge guides and decision support tools built into the system might be valuable to physicians for diagnostic and treatment purposes.
- Group practices and participating physicians might find added opportunities for cost containment.

Mr. Uzych is an attorney specializing in health law based in Wallingford.

Evolution of computerized systems

In November 1988 the Harvard Community Health Plan, a major New England health maintenance organization (HMO), together with Electronic Data Systems Corporation, a Dallas-based unit of General Motors, combined in a joint venture to form InterPractice Systems (IPS). The purpose of the venture is to develop computer-based information systems. In substance, IPS provides systems and consulting services pertinent to the clinical and business aspects of managed health care. Physicians and patients are connected electronically to one another, and to needed administrative and technical support.

The use of computer-based information systems, in general, may achieve readily available, quality clinical care for patients while containing costs, and may also provide access to desired information for physicians. The IPS communication system, in particular, encompasses various areas of practice, including an electronic medical record, practice administrative support, appointment scheduling, results management, and clinical decision-support guidelines, thus potentially resulting in a more efficient practice environment.

Furthermore, the IPS system is designed to increase appropriate access to health services while at the same time reducing unnecessary appointments. The system may be accessed using a computer terminal, which might be located either at home or at a worksite. The necessary computer hardware includes a monitor, a keyboard, and a built-in modem to facilitate electronic transmission.

Health-related questions may be answered and advice given to users in accordance with on-line and written instructions designed to help users make appropriate selections. HMOs and other managed care entities might use the IPS system to communicate effectively with

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members. Several HMOs have already reportedly indicated an interest in the computerized service.

The need for monitoring

Computerized services may offer potential advantages, yet important issues remain open. The possible reduction in patient visits may, in some respects, be cost beneficial, but what if patients delay acquiring needed medical care? It would be helpful if more data were collected germane to potential effects of a computerized system on patterns of utilization of medical services and the effects on overall levels of patient satisfaction. Some patients may feel more comfortable working with an electronic information system, especially if the subject involved is perceived to be embarrassing. Other patients may dislike the lack of personal or face-to-face contact with providers, and yet others may generally dislike, fear, or feel uncomfortable working with a computer system.

Introducing to patients a new system, perceived to be cost efficient yet disadvantageous to clinical care, may be unwise. The physician community needs to monitor carefully the evolution of computerized communications systems, particularly for effects on quality of care, access, and cost ramifications.

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Before using the request service, the user must sign an agreement with a LOANSOME DOC® provider library. Libraries may charge for this service to cover processing costs.

In Pennsylvania, Falk Library of the Health Sciences at the University of Pittsburgh has been awarded an Outreach Services Program contract from the New York Academy of Medicine, a regional medical library in NLM's National Network of Medical Libraries. The program will provide GRATEFUL MED® and LOANSOME DOC® training to practitioners in 30 counties in Western Pennsylvania.

The targeted counties are: Armstrong, Beaver, Bedford, Blair, Butler, Cambria, Cameron, Centre, Clarion, Clearfield, Clinton, Crawford, Elk, Fayette, Forest, Franklin, Fulton, Greene, Huntingdon, Indiana, Jefferson, Lawrence, McKean, Mercer, Mifflin, Potter, Somerset, Venango, Warren, and Washington. For more information, call Outreach Services at (412) 648-3573.

Stephanie Publiker, RN, MLS
Outreach Services Librarian
Falk Library
University of Pittsburgh

Medical Practice Consult: Coding

This continuing column is designed to answer physicians' questions about specific third-party reimbursement and other timely practice management issues they face daily in medical practice. State Society members are encouraged to submit questions, typed on letterhead, to: Medical Practice Consult, Department of Physician Services, Pennsylvania Medical Society, 777 East Park Drive, P.O. Box 8820, Harrisburg, PA 17105-8820. Answers will be solicited from the Society's Practice Management Consulting Network, a group of eight consulting firms in various areas of health care expertise. Answers to the following questions were submitted by The Thayer Group, Inc., Upland, (215) 499-7417.

Explain the use of the modifier "22" for unusual services.

The resource based relative value scale (RBRVS) has maintained the use of the modifier "22" with a descriptor of "unusual procedural services." This modifier carries with it financial impact for reimbursement. The law provides for carriers to increase payment where medical care has been provided above and beyond the highest level of service provided in each category of care. When reporting modifier "22," always include required supporting documentation. Claims cannot be submitted electronically using supporting documentation; all claims with the use of modifier "22" require manual review by the carrier.

When resubmitting a claim due to an error, is there a modifier that can be used to alert third-party payors that it is not a duplicate billing?

No. Most third-party payors will respond in payment or rejection within 45 days. If payment has not been received within 45 days, the protocol for handling is as follows:

For Medicare: Submit a review for non-payment, and attach a copy of the original claim form. This is applicable to hard-copy claims only; the protocol for electronic claims is supplied by your software vendor.

For commercial carriers: Submit a copy of the original invoice with a cover letter explaining it is a resubmission of a claim. Optimal results can be achieved by placing a call to the commercial carrier requesting a status report of the claim. Most commercial carriers offer an 800-number.

For Pennsylvania Medical Assistance: Simply resubmit the claim if no response of payment or denial is received within 45 days.

When are HCPCS codes used in lieu of CPT codes?

HCPCS (Health Care Financing Administration Common Procedure Coding System) codes have historically been used for medical services provided to Medicare patients. With implementation of evaluation and management (E/M) services, CPT (Common Procedure Terminology) codes were designed to be universally accepted by all third-party carriers. Effective January 1, 1992, Medicare is the leading third-party carrier to adopt CPT E/M codes to be synonymous with HCPCS codes. Physicians should be cautious of the following:

- While the AMA has designed E/M codes to be both CPT and HCPCS, it is not assured that all or any commercial carriers will quickly adopt the new E/M codes. It is recommended that a trial claim be submitted from the medical practice to test the waters of commercial carriers. Commercial insurance carriers historically pay promptly; and when there is a conflicting concern, they frequently will place a telephone call to the medical practice for confirmation.
- National and local carrier codes will continue to exist for services rendered to patients. Use of the local codes as they are unveiled will require careful review of interpretation.

How do you code for concurrent care by two physicians so both are paid?

Concurrent care has been—and remains—a hot issue for patients requiring medical services by two physicians on the same day. Medicare has been disallowing this service and will continue to do so under RBRVS unless it is "Medicare's opinion and interpretation" that two distinct diagnoses warrant that two distinct and separately identifiable services were provided by two separate physicians. The level of E/M services will continue to be honored on a first-physician claim basis. The second-physician claim will warrant individual review and interpretation of services by Medicare.

Under what circumstances should a physician request a hearing for a Medicare claim?

Medicare can reject a claim and will issue the reason for rejection on the "Explanation of Medicare Benefits." If a physician/provider believes a service was warranted for reimbursement, a review can be submitted to Medicare using a Medicare inquiry form. If Medicare rejects the claim on the second review and the dollar amount in question is more than $100, the physician has the right to request a fair hearing. If Medicare does not give one, write to the Medicare Fair Hearing Office and request one.

Note: information in this column should not be interpreted as a substitute for legal or other expert advice. For a listing of Practice Management Consulting Network participants, call the Society's Department of Physician Serivces at 1-800-228-7823.

QUESTIONS ON PRACTICE MANAGEMENT?

This page is for you and your office manager. Write to us as directed in the box above.

COMPUTERS CAN EASE MANAGEMENT FUNCTIONS

All too often physicians fail to reap the full benefits of the practice management functions their computers offer. In fact, an office computer is actually an investment that can yield larger dividends to the practice than physicians and staff may realize.

In addition to the more widely used capabilities, software is now available that makes it easier not only to compile many types of management data, but also to share financial and clinical information between hospitals (or managed care providers) and practices. Today's computer systems perform numerous financial management and reimbursement functions that make the job easier, such as billing, fee and reimbursement, coding review, managed care, and marketing functions. Additionally, some of the newer programs—such as clinical management programs and links to managed care plans—can enhance quality of care as well as office efficiency.

Billing functions

In many practices, computers are used merely to generate bills; however, billing efficiency could be significantly improved by adding new software that links a practice directly to the principal hospital's computer, providing physicians with patient registration and demographic data. This immediate access to hospital admission, discharge, and consultation data, and emergency room sheets could dramatically streamline staff efforts and reduce turnaround time.

Also, if physicians set payment schedules for patients, but fail to send a written copy of the agreement to them or fail to verify that payments are being made, computers can print payment schedules and collection notices and be programmed to track payments and list patients who missed promised deadlines. Physicians can use such lists to contact those patients quickly, keeping collection efforts on schedule and speeding up cash flow.

Fee and reimbursement functions

A good system should be able to report—by payor—the range of reimbursements for every procedure that physicians perform. Physicians should use such background data to review and adjust fees each year, and to run a list of the number of times each procedure is performed. When analyzed with the reimbursement data, these numbers give physicians a profile of revenue centers. This type of information is valuable, too, for budgeting, marketing, and strategic and resource planning.

Coding review functions

Computers can be used to check coding accuracy and identify poor coding patterns. Computer-aided coding reviews can reveal inappropriately high use of non-specific diagnosis codes or of a single level of service. Physicians' coding practices can be observed, helping identify both practice-wide problems and individual digressions from established coding policy. Also, the system helps physicians analyze fee adjustments by showing how much discounting is occurring, if adjustments are caused by coding errors, and which insurers have been reimbursing improperly.

Managed care functions

System data can be used to evaluate contracts from health maintenance organizations (HMOs) and preferred provider organizations (PPOs). Computers can produce detailed analyses of revenue from each plan in which a physician participates, helping to evaluate financial gains or losses from participation. Physicians may then compare each plan's turnaround time in making payments for services rendered and review the percentage of patients originating from each plan.

Marketing functions

To guide marketing strategies, physicians can use data on how many patients are received from each referral source. Recall procedures should be streamlined through a computerized follow-up system. Many software packages not only compile the recall list and general recall form letters, but also cross-reference recall notices with scheduled appointments. Computer word processing functions are also useful for printing patient education materials and newsletters.

Clinical management programs

In addition to billing link-up functions previously mentioned, hospitals are creating computer networks to share clinical and scheduling information. For example, diagnostic tests can be scheduled directly with a hospital, reducing waiting time for patients and administrative time for staff. Afterwards, the system transmits test results directly to a physician's office. While earlier software generations allowed physicians to view the clinical data, the data could not be stored effectively, manipulated, or printed in different formats.

Today, the latest versions allow physicians to store clinical data as a separate file, from which they can print the information in whatever form is needed. As networking technology develops further, physicians should be able to integrate clinical data with a billing system to ease billing routines.

Links to managed care plans

Computer vendors and larger managed care plans are working to give physicians access to managed care groups' records. The first stage of this undertaking has two goals: 1) to give practices immediate information on eligibility, allowable services, and required co-pays; and 2) to provide fast approval for referrals—which will reduce paperwork and improve collections. The second stage, then, includes electronic claims submissions and rapid reply on claims statuses.

To track these and other important telecommunications developments, physicians should talk to their hospital and HMO information service experts *before* deciding on new purchases or modifications to telephones, modems, or computer systems. Physicians may want to obtain hardware and software compatible with those in their hospitals and managed care systems.

Maintaining a computer system that is not fully integrated into practice management activities costs time and money. Dollars invested are wasted in an under-utilized computer, and physicians lose the potential savings from cost-effective operations. Poor computer use also makes an office less efficient, placing more pressure back on the medical practice. Keep up-to-date with software and hardware developments by staying in touch with vendors and reading articles about medical office computers.

The contributing authors, Patricia M. Salmon and Paul W. Smith, CPBC, are consultants with The Health Care Group, a medical practice management consulting firm based in Plymouth Meeting.

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ACTIONS OF THE BOARD OF TRUSTEES, MARCH 11, 1992

SOCIETY WILL SEEK AMENDED LANGUAGE

As House Bill 20, the Health Care Partnership Act, passed the state House of Representatives, Society lobbyists worked successfully to remove language tying licensure and medical staff privileges to mandated Medicaid participation. The bill is now awaiting movement in the Senate Public Health and Welfare Committee.

The House-approved bill contains a provision for physician referral networks in lieu of mandatory Medicaid participation attached to medical staff privileges. However, the responsibility for the network has been placed on the hospital. The Society believes that hospital medical staffs, rather than hospitals, should be responsible for access to physician services.

Also, an added clause provides that effective referral networks already in existence would be considered in compliance with the proposed act, eliminating the need to develop new programs in areas already effectively served. If movement occurs in the Senate, Society lobbyists will work for these additional changes approved by the Board of Trustees.

ACTING SECRETARY DISCUSSES HEALTH BUDGET

Alan S. Noonan, MD, MPH, acting secretary of the state Department of Health, attended the board's March meeting to discuss Pennsylvania's proposed budget "from a health point of view." He said the governor told him last year that health was a priority, and Dr. Noonan is "encouraged" by the proposals for the next fiscal year.

The 9.6 percent increase in the Department of Health budget is the largest proposed for any state department, according to Dr. Noonan. Increases have been proposed for several programs, including AIDS training and education, immunization, and development of an incentive program to increase the number of primary care providers in Pennsylvania.

SOCIETY CONCERNED ABOUT HCFA SURVEY

The Pennsylvania Medical Society expressed grave concerns with the Medicare Current Beneficiary Survey (MCBS) being conducted by the Health Care Financing Administration (HCFA). In a letter approved by the Society's Board of Trustees, the Society relayed its concerns to Louis W. Sullivan, MD, HCFA's secretary of Health and Human Services.

The Society identified several weaknesses in the MCBS, designed to research the effects of physician payment reform and other Medicare policies on beneficiary access. According to the letter to HCFA, the State Society "questions the study's ability to satisfy [its] intent,...[is] offended by several of the patient satisfaction questions and objects to the collection of this information on a physician-specific basis."

At this time, the Society is awaiting HCFA response to the letter. However, to remedy the final concern, the board in another action approved a recommendation of the Council on Governmental Relations that the Society request AMA to study whether a better-designed study, to be conducted by the AMA, was warranted.

BOARD AUTHORIZES LEGAL ACTION

The Board of Trustees authorized legal action against the state Department of Public Welfare and the U.S. Department of Health and Human Services to contest the failure of Medicaid to pick up Medicare co-insurance payments for the elderly poor eligible under both systems.

Medicaid currently pays Part B premiums for Medicare plus a deductible for dual eligibles; however, it does not pay the 20 percent co-insurance premium. Society legal staff estimates the amount owed to Pennsylvania physicians from co-insurance payments due ranges between $25 and $45 million. In a similar New York lawsuit, physicians were successful in regaining money due. The Society's law suit will seek to do the same.

PRIORITIZATION POLICY ADOPTED

In response to the on-going debate about prioritization versus rationing of health care, the board adopted a policy statement which makes a clear distinction between the two and states the Society's view of both.

The subject was hotly debated during the 1991 House of Delegates meeting, where members of the House agonized over the involvement of organized medicine in any form of health care rationing. Rationing is "a process that restricts the application of resources to those medical services, categories of services, and/or treatment options ranked higher on a priority lists and denies access to others by, in effect, drawing a line," according to the statement. It also states that organized medicine should not be responsible for the rationing of care.

Prioritization, however, is defined as "a process that ranks medical services, categories of services, and/or treatment options on the basis of value," which is derived from both non-economic and economic benefits of services and options. The Council on Education and Science, which recommended adoption of the statement by the board, believes that physicians should be involved in prioritizing health care so it is not done without physician participation.

The policy statement will be presented to the House of Delegates at its October meeting for further ratification.

SOCIETY PURSUING BILLING SERVICE

The trustees approved a recommendation of the Council on Medical Practice that the Society pursue development of an electronic billing service for use by all Society members. According to the Council's report, the service would:

1) electronically bill many major third-party insurers in the state,

2) increase the speed of transmission of electronic claims,

3) allow the Society to monitor claims payment practices of third parties,

4) provide a competitively priced alternative for physicians in the event third-party insurers institute penalties for paper claims submission,

5) offer the opportunity for physicians to introduce computers into their practices, and

6) allow the Society to offer other computer-based products.

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FIVE SOCIETY SEMINARS ON OSHA ADDED IN APRIL

With the release of new standards of the Occupational Safety and Health Administration (OSHA) on occupational exposure to bloodborne pathogens, the Society scheduled three half-day seminars at the end of April to help members and their office staffs with implementation. An overwhelming response from potential attendees led the Society to add five seminars to the original schedule.

More than 660 physicians and members of their office staffs attended the eight half-day seminars in King of Prussia, Harrisburg, and Pittsburgh, April 21-24. A consultant with Practice & Liability Consultants, a health care practice management and risk management firm, addressed general compliance topics, personnel recordkeeping and training requirements, discipline documentation, universal precautions, infection control techniques, and other pertinent topics. Attendees received the necessary components of an Exposure Control Plan as required by the regulations, and a seminar outline.

Exclusively for members unable to attend a seminar, the Society is offering an OSHA Information Kit containing all documentation necessary to comply with the regulations. Kits are available from the Society's Department of Physician Services for $10 each plus tax. For fastest delivery, complete and mail to the Society a copy of the OSHA Order Form included in the May issue of *Executive Report*. For more information, call 1-800-228-7823.

DELEGATION NEWS

AMA DELEGATES DEBATE RESOLUTIONS

The Pennsylvania Medical Society's delegation to the American Medical Association in April debated a number of resolutions for possible introduction at the AMA Annual Meeting in Chicago in June.

Those resolutions *finalized* for introduction address the following issues: subpoena power for the Food and Drug Administration, alternatives for board recertification examinations, establishment of college campuses as smoke-free



Members of the Pennsylvania delegation to the AMA met in April to discuss resolutions under consideration for introduction in June to the national delegation. Pictured (left to right) are: George F. Buerger Jr., MD; Donald C. Brown, MD; and John A. Malcolm Jr., MD.

environments, compliance of residency programs to provide a broad year of general training to most first-year residents, tax treatment of individual insurance, and Health Access America, AMA involvement in and reporting of development of proposals for funding and structure of graduate medical education, AMA involvement in changing concurrent care payment policies, and AMA reaction to aspects of HCFA's Health Care Quality Improvement Initiative.

Also at the June meeting, the delegation will support two candidates for seats on AMA councils: State Society President Robert N. Moyers, MD, a family practitioner from Meadville, is seeking a position on the Council on Medical Education; and Ronald J. Clearfield, MD, a radiologist in New Kensington, will run for a position on the Council on Constitution and Bylaws.

SOCIETY DISTRIBUTES AIDS GUIDE TO MEMBERS

The State Society recently published a booklet containing information for physicians on AIDS. It also includes a new Department of Health reporting form released in February and information about the final regulations on occupational exposure to bloodborne pathogens issued by the Occupational and Safety Health Administration.

The publication, developed specifically for physicians by the Society's Commission on Public Health, Subcommittee on AIDS, describes, among other topics: the State Society's policy on AIDS including patient care, education, testing, couseling, confidentiality, and public policy; counseling information, such as a sample patient information statement, sample consent form, and disclosure of HIV test results; safe sex guidelines; information about diagnosing AIDS and HIV positivity; the pathogenesis of HIV; and testing information.

This second edition of the Society's booklet was distributed, through funding from the Society's Educational and Scientific Trust, to each member physician in early April.

COUNTY NEWS

ACMS HOSTS MEDIA TRAINING

In February, the Allegheny County Medical Society (ACMS) hosted a half-day media training seminar for physicians. Pat Wood, State Society director of media relations, explained medicine's role in the media, and attendees were provided with practical techniques in managing the interview process.

A panel of local reporters explained the news-gathering and dissemination process and answered physicians' questions regarding medicine in the media. Representing print and broadcast media were: Mark Roth, assistant managing editor, *Pittsburgh Post-Gazette*; Steve Twedt, medical reporter, *The Pittsburgh Press*; Stacy Smith, news anchor, KDKA-TV; and Dan Splain, talk show host, KQV-AM radio.

SPECIALTY NEWS

ACADEMY PRESENTING ANNUAL MEETING

The Pennsylvania Chapter of the American Academy of Pediatrics will present its annual meeting May 22-24, 1992, at the Sheraton Hotel at Station Square, Pittsburgh. The session is entitled "Meeting the Challenge: Special Care for the Special Child."

The meeting will focus on specific diseases and the roles of parents, family members, primary care physicians, sub-specialists, the community, the school nurse, and other health care professionals. Topics of interest to physicians include: what is coordination of care and does it work?, psychological

aspects of chronic illness, management of asthma, Down's Syndrome and seizure disorders, diabetes outpatient management, reimbursement for chronic care, and recent federal initiatives for care of the special needs child.

For additional information about the meeting, credits, or registration, call (215) 520-9123.

THORACIC SOCIETIES TO CONVENE IN FALL

The Pennsylvania and New Jersey Thoracic Societies, along with the American Thoracic Society's Eastern Section, will convene for two days, September 11-12, 1992, at the Hotel Atop the Bellevue, Philadelphia.

Barbara Bates, MD, author and lecturer at the University of Pennsylvania, will keynote the scientific meeting with her presentation, "100 Years: Looking Backward and Looking Forward," a summary of activities of the American Lung Association of Pennsylvania. Other session topics will include gene therapy, cystic fibrosis, lung transplantation, and indoor/outdoor air pollution.

Six Category I CME credits will be offered for the program. For additional information, call Kathi Wagner, chapter administrator of the Pennsylvania Thoracic Society, at (717) 540-8506.

HMSS NEWS

MEDICAL STAFF ASSEMBLY AT AMA IN JUNE

Medical staffs from across the country are encouraged to elect a medical staff representative to participate in the AMA-Hospital Medical Staff Section (AMA-HMSS) Assembly Meeting June 18-22, 1992, at the Chicago Marriott Hotel.

The HMSS assembly provides medical staffs with the opportunity to discuss and participate in the policy-making process of the AMA. In addition to the assembly meeting, participants may attend one of the following educational programs: 1) Medical Staff Bylaws: Principles and Practices, or 2) Outcomes Management: A Medical Staff Issue.

During the first program, legal experts from the AMA and private medical law firms will present a practical overview of the purpose, function, and organization of medical staff bylaws. Topics of discussion will include selected provisions regarding the Health Care Quality Improvement Act, provision for policy statements, and other relevant issues. Participants will also have the opportunity to ask questions pertinent to individual institutions.

In the second program, physician experts in the field of outcomes management and total quality improvement will provide medical staff leaders with a perspective in data collection and outcomes management. They will also be presented with information about how to focus data collection for successful and appropriate application in the interest of improved patient care.

For more information, call the AMA's Department of Hospital Medical Staff Services at (312) 464-4754 or 464-4761.

HMSS NEWS

DR. MOYERS VISITS AROUND THE STATE

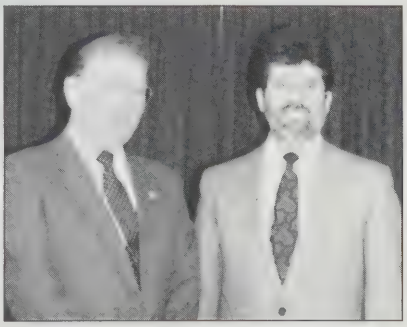
State Society President Robert N. Moyers, MD, (pictured at podium) is fulfulling his inaugural promise of visiting with as many Pennsylvania Hospital Medical Staff Sections (HMSS) and county medical societies as possible this year. Averaging three visits per week, Dr. Moyers has talked with more than 675 physicians and hospital staff members in almost 25 hospitals as of the end of April.



His agenda covers great changes in the medical profession on local, state, and national levels, as well as current issues such as RBRVS, workers' compensation reform, the Medicare Overcharge Measure (MOM), living wills, tort reform, practice parameters, and Medicaid funding. He also emphasizes the importance of physicians uniting through State Society membership.

At a recent visit to Philhaven Hospital, Lebanon County, he spoke with Diehl M. Snyder, MD, president of Philhaven's HMSS (seen below with Dr. Moyers), and 37 of his staff members about fragmentation of the profession through subspecialties and recent legislative activities. Dr. Moyers strongly believes his visits are a step toward reaching "all of the profession" with a message about regaining professionalism and unity and countering "physician bashing" by the media.

Before his presidential term ends in October, he hopes to speak to "at least half" of Pennsylvania's HMSS staff members and county medical societies.



SMALL BUSINESS HEALTH INSURANCE STUDIED

Of the 218,000 small businesses in Pennsylvania, approximately 19 percent do not offer health care insurance for their employees, according to a study commissioned by Pennsylvania Blue Shield. Further results indicate that those businesses would offer insurance, and even share in the cost of coverage, if an affordable, basic benefits package was available.

The percentage of small businesses not offering health care insurance for employees is even greater nationwide, according to the National Federation of Independent Businesses and the Small Business Administration. Of six million small businesses in the nation, between 34 and 48 percent do not provide health care insurance for employees.

The results demonstrate that "most small businesses prefer to offer health care coverage to their employees, but cannot afford to do so," according to Karen Early, public affairs manager at Pennsylvania Blue Shield, who directed the study in late 1991. She adds that the results also "support the development of tax incentives for small businesses to offer health insurance."

1991 in Retrospect

Donald E. Harrop, MD

At the end of February, the Keystone Peer Review Organization mailed its annual report to all practicing physicians in Pennsylvania. This article briefly summarizes highlights of that report and discusses the organization's recent accomplishments.

Now that all the numbers for 1991 are in and verified, we can look back and ask ourselves, "What kind of a year has it been in terms of the Keystone Peer Review Organization's (KePRO's) accomplishment of objectives, and the expectations of our parent company, the Pennsylvania Medical Society?" Those who read KePRO's 1990-91 annual report would probably agree that 1991 was successful and that the organization's reputation is being continuously enhanced through the various policies and procedures intended to maintain maximum fairness in the review system.

Statistically, the annual report displayed a number of charts and graphs which reflect the success of the policies set by the Board of Directors. The most important of these was the revision made to the quality review process, which added another opportunity for physicians to discuss potential quality of care concerns without compromising our contractual obligations to the Health Care Financing Administration (HCFA). All indications are that this has greatly reduced physician anxiety over the review process and eliminated much past hostility because the initial letter is now merely a request for additional information rather than being labeled a pending quality of care concern.

Almost an entire page of the report presented information to assist health care providers in avoiding the most frequent, confirmed quality problems and HCFA generic quality screen failures. The report contains several examples of the types of cases in which confirmed problems or screen failures are most often identified, and recommendations for avoiding situations which cause KePRO to raise questions about quality of care.

Another section describes the KePRO physician advisor credentialing process which is somewhat unique. We believe that it has contributed to increased physician acceptability of the PRO program: more and more people are becoming aware that all KePRO peer reviews are conducted by board-certified specialists who have active hospital admitting privileges and who have been credentialed by committees comprised of physicians from their own county medical societies.

KePRO has also been striving to strengthen its financial base by seeking other review contracts in addition to Medicare review in Pennsylvania. In March 1992, a contract with the Southeastern Pennsylvania Transit Authority (SEPTA) was renewed for another year, and a contract was signed with the Florida Department of Health and Rehabilitative Services to conduct the Medicaid review in that state. We have also developed a joint venture with the Florida Medical Association for the purpose of bidding on the Florida Medicare PRO contract. However, HCFA withdrew their Request for Proposal because of an anticipated decrease in funding for the program shortly after our proposal was submitted, and the contract was awarded to the fiscal intermediary in lieu of a PRO for the remainder of 1992. Another proposal for that contract will be submitted later this year.

Financially, KePRO has been able to operate at a profit during a time when some PROs have suffered losses. This can only be attributed to diligent application of sound management practices. A dividend was paid to our only stockholder, the State Society, during 1991. We hope another can be paid in 1992 if KePRO maintains a sufficient excess of income over expenditures. Overall, KePRO's board considers 1991 successful, and it appears that 1992 is off to a good start.

Dr. Harrop is president of the Keystone Peer Review Organization.

Whitney C. Corsello, *Pittsburgh*
Hahnemann University School of Medicine, 1937; age 80, died February 11, 1992. Dr. Corsello was a general surgeon.•

C. Nelson Davis, *Merion Station*
Temple University School of Medicine, 1931; age 88, died March 12, 1992. Dr. Davis was a psychiatrist.•

Jose G. Guzman, *Bethlehem*
University of Santo Thomas Medical School, Philippines, 1956; age 59, died February 11, 1992. Dr. Guzman specialized in emergency medicine.•

George A. Jones, *Steelton*
Howard University College of Medicine, 1935; age 87, died February 26, 1992. Dr. Jones was a dermatologist.•

Robert B. Silverman, *York*
University of Miami School of Medicine, 1973; age 44, died February 6, 1992. Dr. Silverman was a pathologist.•

Howard M. Simons, *Elkins Park*
Hahnemann University School of Medicine, 1961; age 56, died February 18, 1992. Dr. Simons was a dermatologist.•

Harold L. Bess, *Levittown*
University of California, Irvine, California College of Medicine, 1954; age 67, died February 22, 1992.

Ralph Cantafio, *Doylestown*
Temple University School of Medicine, 1938; age 78, died January 18, 1992. Dr. Cantafio specialized in occupational medicine.

William M. Conway, *Holidaysburg*
Loyola University of Chicago Stritch School of Medicine, 1939; age 78, died February 20, 1992. Dr. Conway was a general surgeon.

Barbara M. Frank, *Wexford*
University of Pittsburgh School of Medicine, 1963; age 54, died January 8, 1992. Dr. Frank was a pediatrician.

Alda de Sam Lazaro,
Age 74, died January 28, 1992. Dr. Lazaro was a psychiatrist.

Christopher S. May, *Philadelphia*
Hahnemann University School of Medicine, 1988; age 29, died January 21, 1992. Dr. May was an internist.

Michael S. Mermon, *Nesquehoning*
Jefferson Medical College, 1933; age 83, died January 30, 1992. Dr. Mermon was a general practitioner.

Edward G. Torrance, *West Chester*
University of Minnesota Medical School, 1924; age 93, died February 19, 1992. Dr. Torrance was an internist.

A. Carl Walker, *Waynesburg*
University of Pennsylvania School of Medicine, 1931; age 86, died February 28, 1992.

• Denotes membership in the Pennsylvania Medical Society at time of death.

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Paul D. Siegel, MD, Philadelphia internist, was newly appointed to the board of directors of the Pennsylvania Medical Society Liability Insurance Company (PMSLIC).

Marjorie A. Bowman, MD, MPA, professor and chair of the Department of Family and Community Medicine at the Bowman Gray School of Medicine of Wake Forest University in Winston Salem, North Carolina, was appointed editor of the *Archives of Family Medicine*.

Ted S. Eisenberg, DO, FACOS, plastic and reconstructive surgeon at Suburban Genral Hopsital in Norristown, has been named plastic surgery consultant for the American Osteopathic Board of Surgery.

Paul Lotke, MD, chief of implant services and a knee specialist in the Joint Reconstruction Center at the University of Pennsylvania Medical Center, has been named president of the Knee Society.

Jose F. Caro, MD, internationally known diabetes expert, has been appointed chairman of the Department of Medicine at Thomas Jefferson University.

Gloria J. Watkins, MD, pathologist at Frick Community Health Center in Mt. Pleasant, was named president of the Westmoreland County Medical Center.

Edwin W. Shearburn III, MD, surgeon at Grand View Hospital in Sellersville, was elected president of the Bucks County Medical Society.

The Schuylkill County Medical Society has installed the following 1992 officers: **Samuel C. Slimmer Jr., MD,** medical director of emergency services at Pottsville Hospital and the Warne Clinic, president; **A. Mohsen Kholoussy, MD,** chairman of the Department of Surgery at Pottsville Hospital, president-elect; **Robert H. Peters III, MD,** gastroenterologist, treasurer; and **Joseph T. Marconis, MD,** vice president of medical affairs at Pottsville Hospital, secretary.

Paul J. Fink, MD, chairman of the Department of Psychiatry at Albert Einstein Medical Center and medical director at Belmont Center for Comprehensive Treatment, has been appointed to the Philadelphia Board of Health.



Dr. Fink

Charles M. Baney, MD, retired this year after practicing family medicine in Hamburg for 35 years.

Charles E. Gregg, MD, was named physician-in-charge of the anesthesia service at Chestnut Hill Hospital in Philadelphia.

An article entitled, "Euthanasia," by **Stanley M. Marks, MD,** past president of the Allegheny County Medical Society (ACMS), will be reprinted in the "Other Opinion" section of the AMA's *American Medical News*. The article was originally published in the January 11, 1992, issue of the *ACMS Bulletin*.

Charles E. Gregg, MD, was named physician-in-charge of the anesthesia service at Chestnut Hill Hospital in Philadelphia.

James P. Bradley, MD, Pittsburgh orthopaedic surgeon, was inducted to fellowship in the American Academy of Orthopaedic Surgeons.

Jonathan D. Rubin, MD, diagnostic radiologist, was appointed medical director of the Department of Radiology at Mt. Sinai Hospital in Philadelphia.

William E. Benson, MD, Overlook, was named director of the Wills Eye Hospital Retina Service. He succeeds **William H. Annesley Jr., MD,** who, in addition to continuing as a Retina Service attending physician and an active practitioner, will continue as head of the Vitreoretinal Foundation.

Alexander J. Brucker, MD, chief of the Retina and Vitreous Service for the Department of Ophthalmology of the University of Pennsylvania School of Medicine at Scheie Eye Institute in Philadelphia, was elected president of the Macula Society. The Society is an international organization of ophthalmologists who subspecialize in the care of patients with diseases of the retina.

Jeffrey T. Kirchner, DO, a member of the Department of Family Practice at St. Joseph Hospital in Lancaster and clinical preceptor in the Department of Family and Community Medicine at Lancaster General Hospital, has been named to the editorial board of *Postgraduate Medicine*.

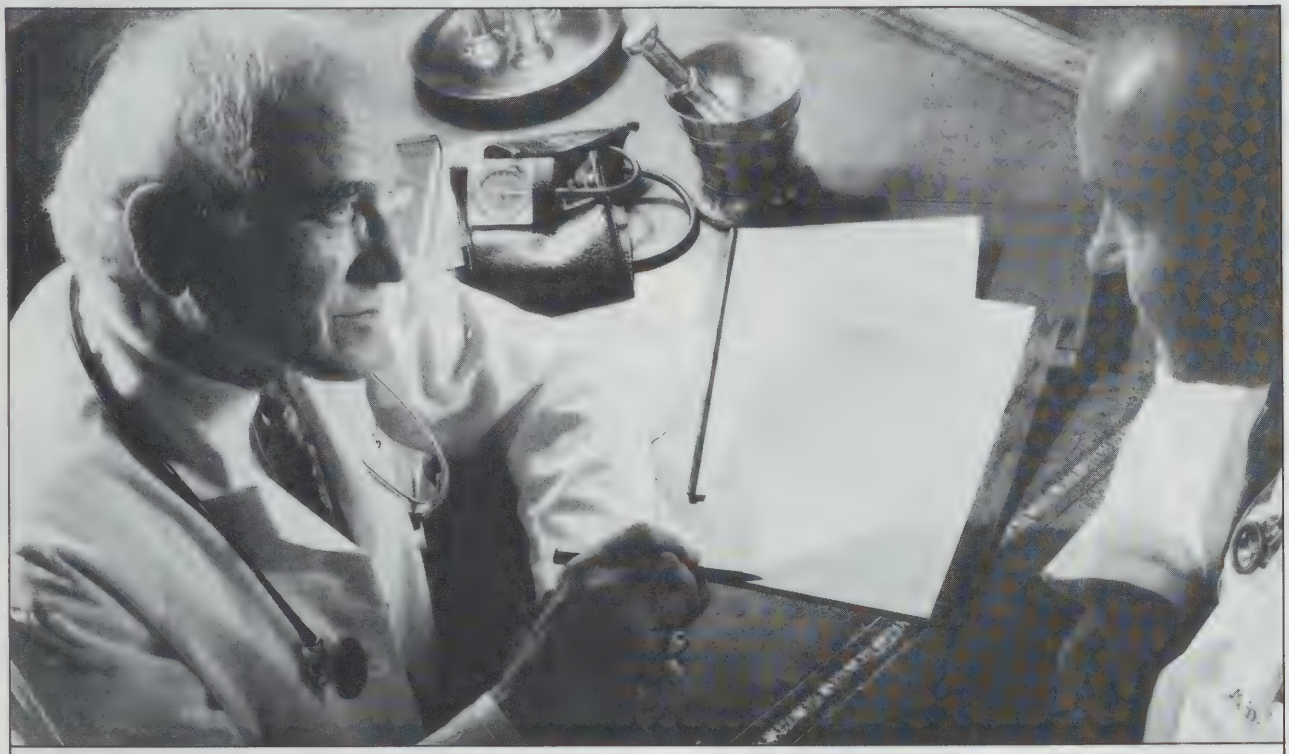
James H. Herndon, MD, the David Silver professor and chairman of the Department of Orthopaedic Surgery at the University of Pittsburgh School of Medicine, has been elected chairman of the Residency Review Committee for Orthopaedic Surgery.

Scott P. Henry, MD, was appointed medical director of the Endoscopy Center at Hamot Medical Center in Erie.

Sheldon H. Linn, MD, obstetrician/gynecologist at Grand View Hospital, has been board certified by the American Board of Obstetrics and Gynecology.



The Commonwealth Board of the Medical College of Pennsylvania (MCP) annually awards and funds two National Health Policy Fellowships for medical students to participate in a summer internship program in Washington, DC. The program gives selected MCP students first-hand experience in health care policy making at the federal level. Pictured (left to right) are: Francine M. Monohan, 1991 National Health Policy Fellow; Janet Nanorta, manager of community relations at Pennsylvania Blue Shield, Harrisburg; Victoria Wilson, president of MCP's Commonwealth Board; Gilbert D. Tough, chairman of Blue Cross of Northeastern Pennsylvania; and Robert F. Centeno, 1991 National Health Policy Fellow.



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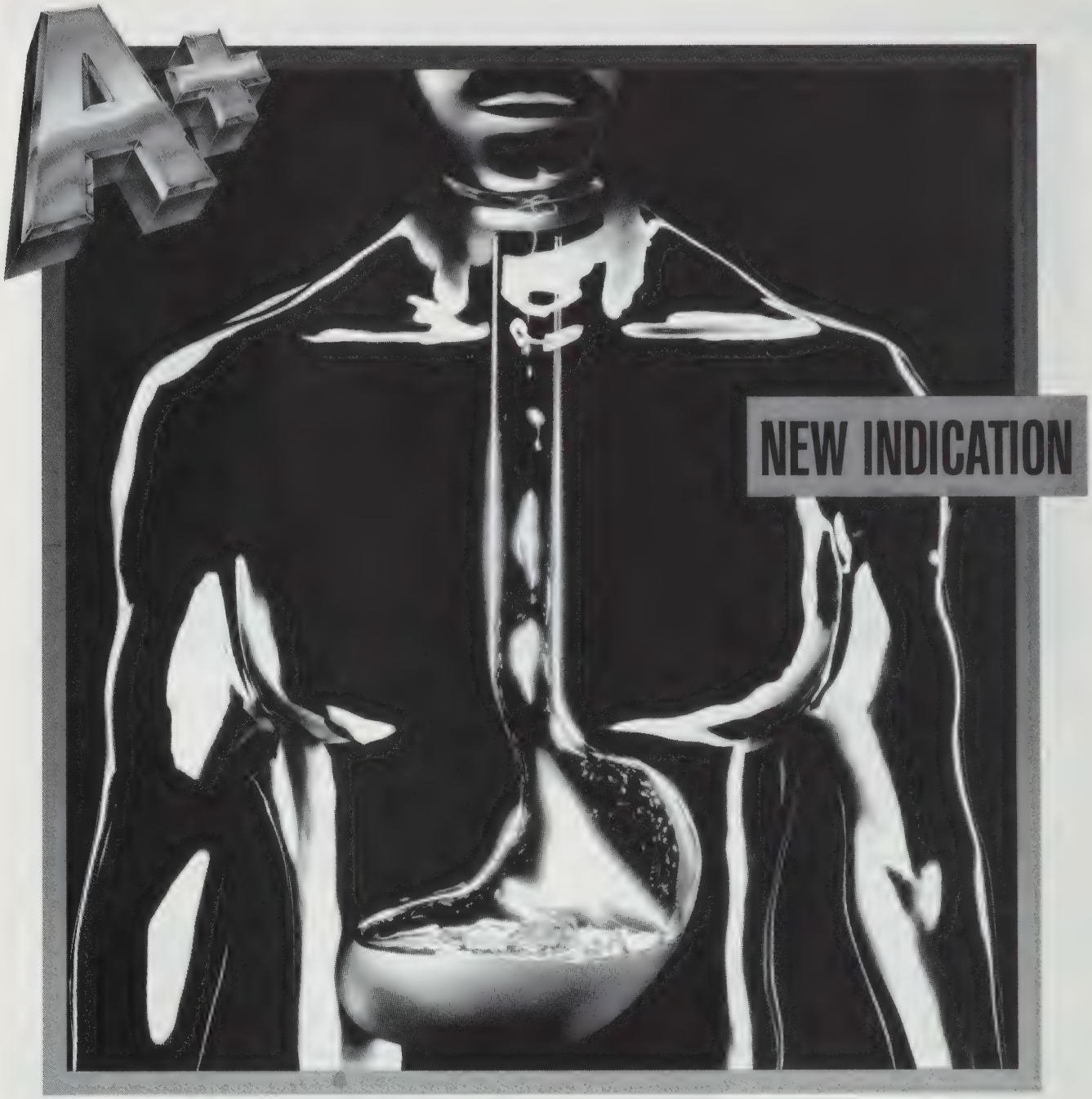
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2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests—False-positive tests for urobilinogen with Multistix® may occur during therapy.

Drug Interactions—No interactions have been observed with theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility—A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups.The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Worldwide, controlled clinical trials included over 6,000 patients given nizatidine in studies of varying durations. Placebo-controlled trials in the United States and Canada included over 2,600 patients given nizatidine and over 1,700 given placebo. Among the adverse events in these placebo-controlled trials, only anemia (0.2% vs 0%) and urticaria (0.5% vs 0.1%) were significantly more common in the nizatidine group. Of the adverse events that occurred at a frequency of 1% or more, there was no statistically significant difference between Axid and placebo in the incidence of any of these events (see package insert for complete information).

A variety of less common events were also reported; it was not possible to determine whether these were caused by nizatidine.

Hepatic—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

CNS—Rare cases of reversible mental confusion have been reported.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of anti-androgenic activity due to nizatidine. Impotence and decreased libido were reported with similar frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic—Anemia was reported significantly more frequently in nizatidine than in placebo-treated patients. Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H_2-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental—Urticaria was reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity—As with other H_2-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. The ability of hemodialysis to remove nizatidine from the body has not been conclusively demonstrated; however, due to its large volume of distribution, nizatidine is not expected to be efficiently removed from the body by this method.

PV 2093 AMP [101591]

Additional information available to the profession on request.

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YOCON®
YOHIMBINE HCl

Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

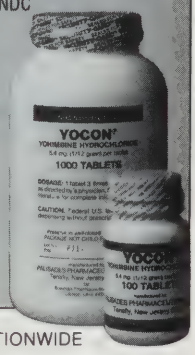
Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.



References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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CORRECTION

In the New Members section of the March 1992 issue of PENNSYLVANIA MEDICINE, Thomas D. Caruso, DO, Montgomery County, is incorrectly identified as a psychiatrist. Dr. Caruso specializes in physical medicine and rehabilitation.



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Physician-Specific Outcome Data: Good or Bad Medicine?

Ferdinand L. Soisson Jr., MD

See the article by John Malcolm, MD, on page 12 of this issue, for a more in-depth discussion of this topic.

The nation is waiting for the Pennsylvania Health Care Cost Containment Council (PHC4) to open the door to physician-specific outcome data. We, the physicians, are perched on the doorstep, deciding whether to go in.

Meaningful data has become a complex issue. PHC4 could sunset this year, adding pressure for the council to generate news and fulfill its mandates. Confusion exists whether PHC4 will cease to be an independent state agency, e.g., becoming part of the Pennsylvania Insurance Department. The level of funding for PHC4 is another subject of controversy, as the Commonwealth sets budgetary priorities for 1992-93. Concerning physician data, the connection between the surgeon and the outcome of coronary-artery bypass procedures isn't as simple as PHC4 pretends; yet the procedures consume enormous resources—as much as $1 in every $50 of health care expenses.

Let us consider the fundamental question: should physicians participate in attempts to measure quality, including outcome research? We have argued that MedisGroups™ outcome morbidity data aren't meaningful and that charge data isn't valid cost comparison. Therefore, is data collection productive and helpful? For business and labor, for example, the reduction of open heart surgery charges at St. Vincent's Hospital in Erie, in response to PHC4 reports, is proof enough that the efforts must continue. We have argued that results to date don't justify the total expense. But hospitals continue to find uses for the financial and MedisGroups™ data, at least raising questions internally about disparate outcomes. We argue the MedisGroups™ data are flawed when utilized in the context of the PHC4 reports. Science demands better. Yet, in medical science, perfection is elusive, and few of us want to risk our patients waiting for it.

We say the data report only a small fraction of quality of care. Yet, what are the ethical considerations of standing in the way of outcome reporting and research, which may ultimately benefit our patients and help control health care costs? We say that the consumer at present cannot use much of these data meaningfully. Yet, major Pennsylvania corporations say they find the data useful, even if flawed. The media asks whether we can offer viable alternatives to these flaws.

Would we generate more public respect and credibility by working within the system, rather than appearing to oppose the system by specific criticisms that may be construed as biased? We say we care about total health care costs; but to fail to support efforts to generate data which may spur competition may cloud our credibility.

Doesn't participation in analyzing data afford the opportunity for new alliances with business, labor, and others; or does obstruction risk our place at the policy-making table?

The question of our commitment to data collection is separate from related issues, such as if PHC4 should sunset, go under a state agency, get more or less money, or be replaced with a non-state operation.

We need to actively educate the public, media, business and labor about data limitations and potential abuse. Data collection cannot be viewed as a simple process to develop or analyze. We must also educate all parties about the dangers of data abuse, particularly with respect to misleading patients and reducing access to care for higher risk patients.

We must increase out credibility as we defend out health care institutions, including individual physicians whose reputations may be unfairly tarnished by such abuse and oversimplification.

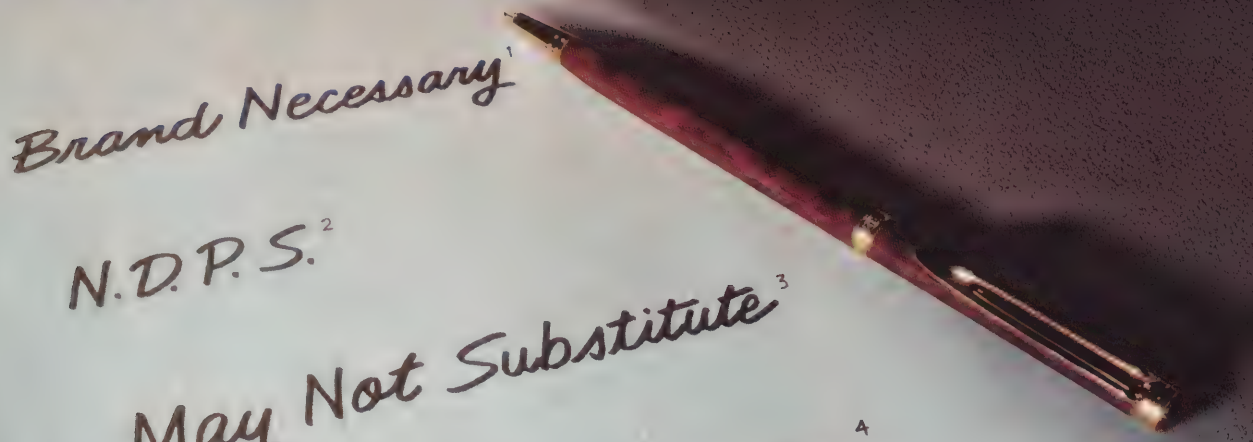
We have a special responsibility not to allow our members, no matter their specialty, to become pawns in this measurement process or allow it to fracture the unity of organized medicine.

The process isn't perfect. Yet if we wait for perfection, we will find that this need obstructs the path to other goals. We must be involved in the "handling and polishing" necessary to form, and perhaps help perfect, the science of outcome research.

It will not be painless or risk-free, but we can exercise greater control by working from within.

Dr. Soisson, who practices office gynecology in Cambria County, holds several positions within the Society including: chairman of the Communications and Management Advisory committees; secretary of the Judicial Council and Bylaws Committee; and member of the Publications, Leadership Conference, and Medical Benevolence committees.

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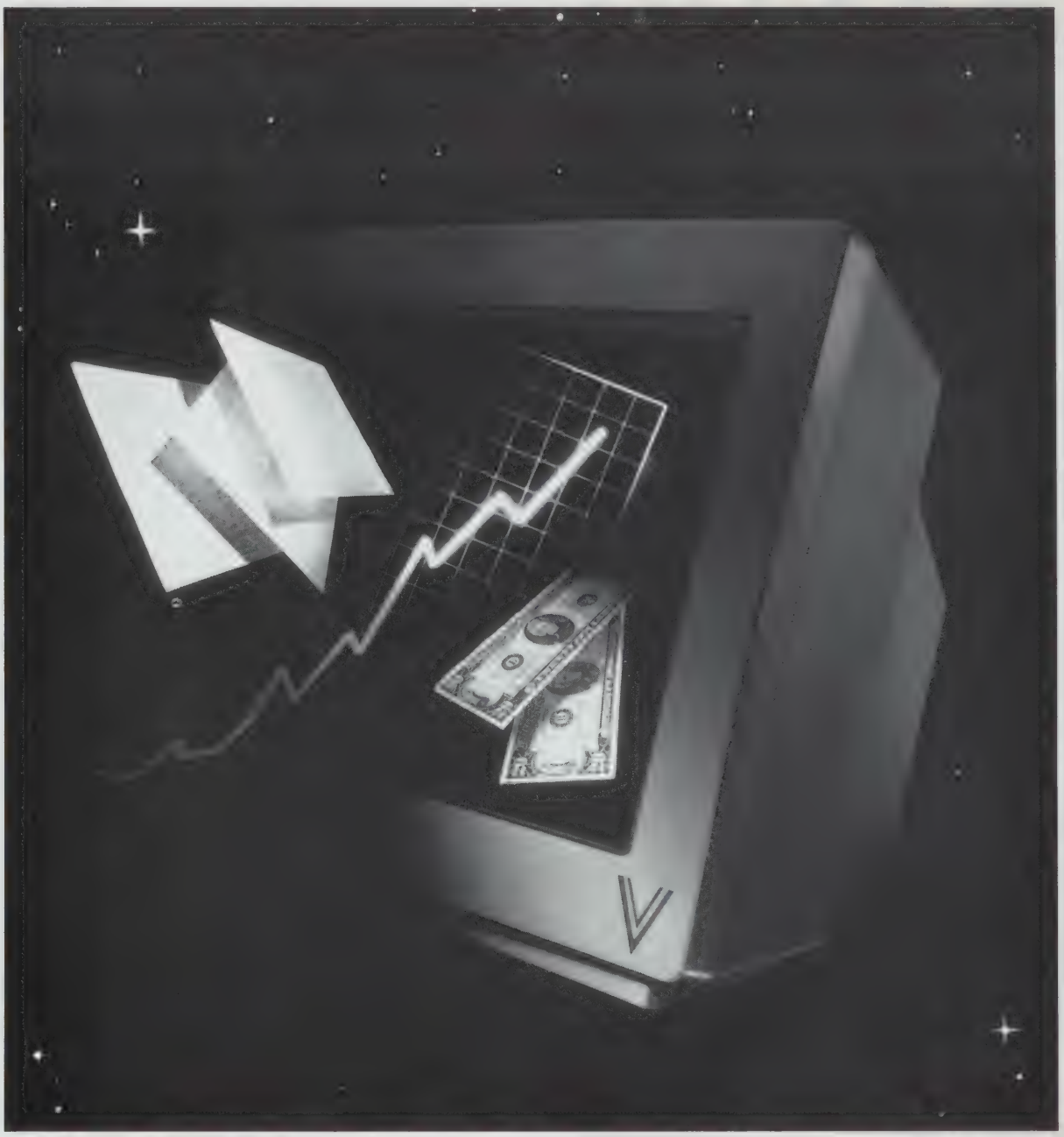
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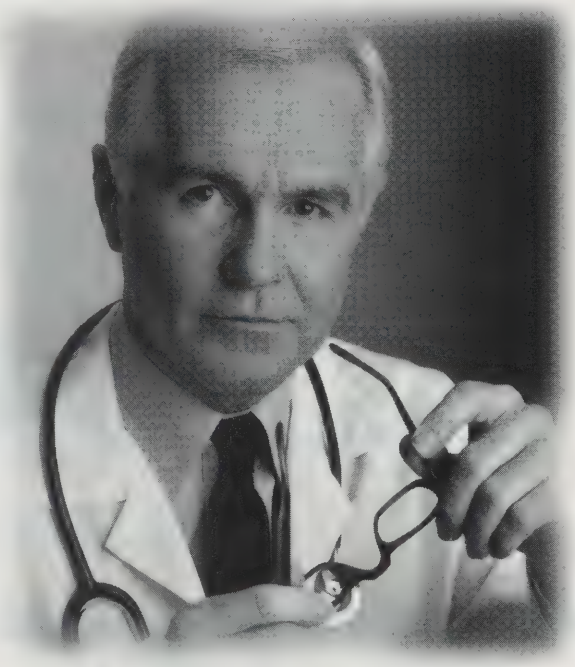
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Cover art by Fred Miles, Harrisburg.

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> *"For physicians, the most poignant part of the report will be the physician and physician practice group data."*

Medigram

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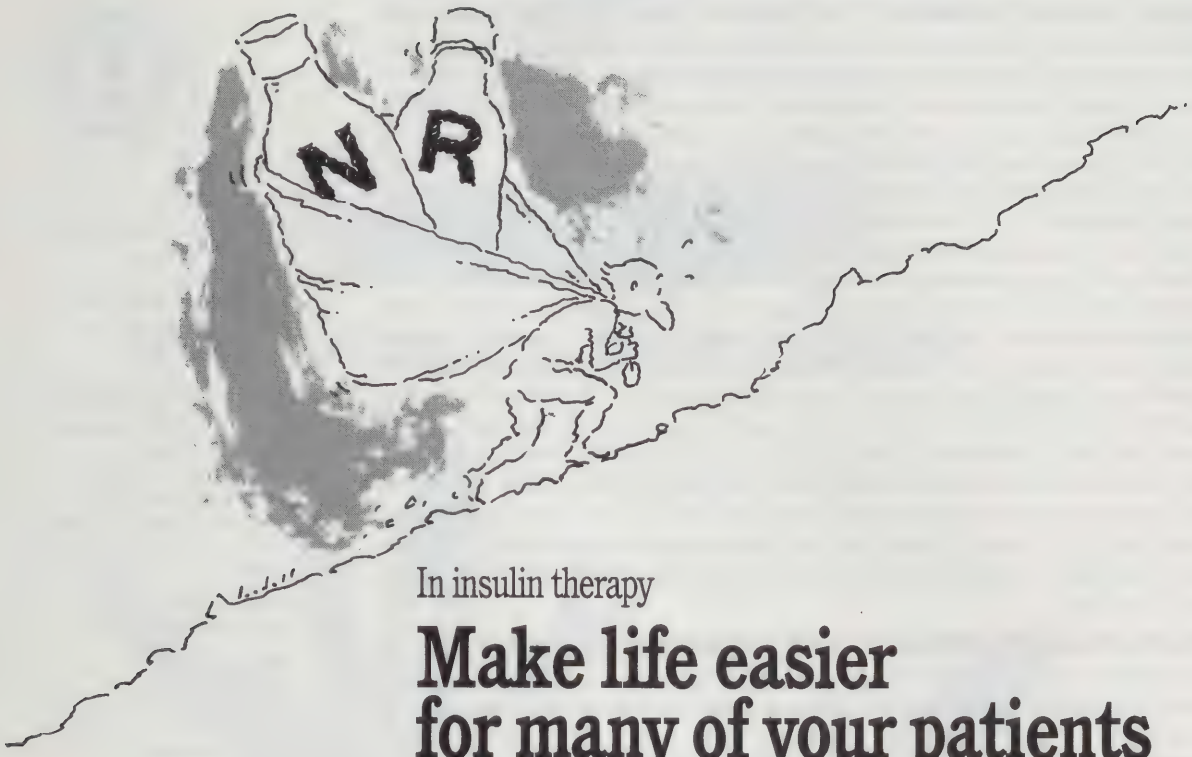
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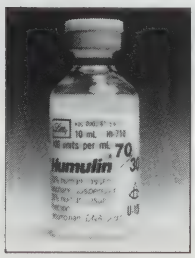
PENNSYLVANIA MEDICINE (ISSN 0031-4595) is published monthly by the Pennsylvania Medical Society, 777 East Park Drive, Harrisburg, PA 17111.
SUBSCRIPTIONS: $20 per year— United States and Canada; $30—all others. Single issues $3.00 per copy prepaid; special issues cost more.
POSTMASTER: Send address changes to PENNSYLVANIA MEDICINE, 777 East Park Drive, PO Box 8820, Harrisburg, PA 17105–8820. Second class postage paid at Harrisburg, PA 17105.



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MEDIGRAM

FEDERAL LEADERS PROMOTE STRICT HEALTH CARE REFORM PLAN: Several members of the Democratic leadership and the majority of the House Ways and Means Health Subcommittee are promoting a health care reform plan that would impose strict government price controls on physicians, hospitals, and other health care providers. The shape and direction of the reform was to be considered at the June 8 meeting of the Democratic caucus. Members of the Society's Federal Key Contact Program have called members of Congress: 1) in opposition to extending Medicare payment policies to private insurers and establishing arbitrary spending caps for public and private health programs; and 2) in support of insurance market reform, professional liability reform, market-based cost containment efforts, and changes in tax policy for health insurance coverage. Also, key contacts traveled to Washington, D.C., on June 5 to meet with top Congressional aides to further relay Pennsylvania-specific and AMA messages. Action by the Rules Committee on potential floor amendments is expected by the end of the month. PHYSICIANS ARE URGED TO CALL THEIR CONGRESSMEN STAT IN SUPPORT OF ORGANIZED MEDICINE'S POSITION. In related news, Representatives Fortney Pete Stark (D-CA), chairman of the subcommittee, and Fred Grandy (R-IA) will address the political realities of reform at a special health care forum scheduled during the AMA's annual meeting later this month.

EFFECTS OF SENATE WORKERS' COMP AMENDMENT STUDIED: The Society's Workers' Comp Quick Response Committee is studying the possible effects of an amended House Bill 2140, addressing workers's compensation issues. The bill, approved by the Senate on May 19 by a 29-19 vote, includes an amendment by Senators Roger A. Madigan and Robert J. Mellow to limit medical payments to 120 percent of the Medicare allowance for 1992. Breaking the tie to Medicare for 1993 and after, the fee schedule would be updated annually according to the percentage change in the statewide average weekly wage. Several other provisions were also included in the amendment. The bill was expected to appear on the House agenda after Memorial Day. For information on Society activities leading up to the Senate vote, see page 22.

SOCIETY-BACKED CHILDHOOD IMMUNIZATION ACT SIGNED BY GOVERNOR: Governor Robert P. Casey on May 21 signed into law Act 35 (House Bill 536), which requires health insurance policies to include immunization coverage and expand availability to younger Pennsylvanians. The new law increases availability of care; eases the burden on public health clinics; insures affordable and minimal immunization costs; and expands the definition of comprehensive coverage to include any immunization for DPT, MMR, polio, and HIB. The Society worked in cooperation with the Pennsylvania Chapter of the American Academy of Pediatrics and the bill's prime sponsor, Representative H. William DeWeese (D-Greene), in support of the legislation.

HHS ISSUES RECOMMENDED MEDICARE CONVERSION FACTOR: Louis W. Sullivan, MD, secretary of Health and Human Services (HHS), in late May issued HHS-recommended Medicare physician payment schedule conversion factor updates for 1993 to Congress. Dr. Sullivan is calling for a two-part update to be applied on a service-specific basis: for surgical services, the recommended update is 2.6 percent; and for nonsurgical services, it is 0.3 percent. Also issued were the following Medicare Volume Performance Standard figures to be used in establishing the 1994 default conversion factor update: 6 percent for surgical services and 7.9 percent for nonsurgical services.

FINAL OSHA BLOODBORNE PATHOGEN EFFECTIVE DATE IN SIGHT: Physicians are reminded that the third and final stage of the Occupational and Safety Administration (OSHA) regulations on occupational exposure to bloodborne pathogens goes into effect July 6. Among other things, employers will be required to provide vaccinations against the hepatitis B virus. For further information, call the State Society at 1-800-228-7823.

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A Sunday "Burnout"

John Mills, MD
Medical Editor

As I write, it is Mother's Day, the close of a very busy week in this doctor's life. Busier than average, I'd have to say, for besides the usual office hours and surgical assists, coupled with two evening medical meetings, reading for the Society board meeting, and accounting paperwork, I've been struggling to comply with the new regulations on bloodborne pathogens from the Occupational and Safety Health Administration (OSHA).

Despite the Society's seminar I attended, and the items I received from the Society and the AMA on the new OSHA rules, I still feel frustrated in trying to comply with the voluminous regulations in such a short time. Appropriate sources for the items we need are difficult to come by: there are half a dozen brands of Glutaraldehyde, all of which are governed by OSHA, Environmental Protection Agency, and Department of Environmental Resources hazard standards. One hardly knows how to use the stuff. I've never received an MSDA (Material Safety Data Sheet) form with any chemical ordered! Clorox rusts my speculums and its use voids any guarantee on fine biopsy instruments! What does one wash the exam tables with? Will the colored naugahyde react with the solution or spray?

Here is another frustrating subject for us physicians: workers' compensation legislation. The State Society has issued two "calls to action" this past week in anticipation of the state Senate's consideration of and voting on the workers' compensation bill. Governor Casey wants it his way or he'll veto it. His recent railing at our profession (during a May 4 press conference) made me see red. He compared our amendments to running his bill through a sausage machine—we would make out like bandits and workers would get the shaft!

A few more incidents like this, and Pennsylvania physicians will react like Massachusetts physicians under Dukakis: they'll leave the state in droves. Will companies have trouble finding physicians to take workers' compensation cases if Governor Casey gets his way? I'm beginning to hear of access problems from Medicare patients. The governor's workers' compensation plan would tie the fees to Medicare and just aggravate the situation.

Earlier, my Sunday afternoon paperwork was interrupted by the beeper to assist at a ruptured appendix with abscess and another acute appendix. Four hours later on this Mother's Day, I am back to trying to cook outside for my wife and me.

Why do we do what we do? Most physicians genuinely like their work and are caring, compassionate people, accepting the awesome responsibilities of medical practice with steadfastness and a sense of duty.

But it's getting more difficult each day. My litany brings me up short when I think about it, as I have for this editorial—being written under deadline pressure.

Medical school and residency are supposed to prepare you for this kind of pressure-packed lifestyle. But they don't prepare you for the likes of politicians like Governor Casey, or the onslaught of government regulations from all those bureaucracies. Add the clinical laboratory regulations to my list—another thorn in the side.

As I look over today's list of things to do, I realize the yard and garden have been completely ignored; the birdhouses are still to be readied for summer. I also note that I missed "60 Minutes" this evening, and their segment on "Physician Burnout!"

Maybe it's good that I didn't see it—for I sometimes feel I've experienced it in short episodes. On the other hand, it might have helped me deal with the overwhelming feeling I have now that I can't accomplish all I have to do this next week.

Thoughtful consideration of my options with my spouse has dissuaded me from cancelling my attendance at the Society's board meeting and the Publications Committee meeting, and from signing out for two days to deal with OSHA, clinical lab regs, corporate taxes, and my sanity.

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The Doctor Is In(undated)

Robert N. Moyers, MD

A recent article in *American Medical News* carried the headline, "Family physicians may finally get more respect." The article was about a change in medical college accreditation, recommended by the Liaison Committee for Medical Education of the AMA and the Association of American Medical Colleges, calling for schools to offer medical students experience in family medicine, general internal medicine, and general pediatrics.

Other recent articles in medical publications have focused on the importance of family medicine departments and the need for good primary care role models for medical students. Why all this interest in primary care? The medical community knows that a sufficient number of primary care physicians can help to mitigate future problems of access and cost in our health care system. But does anyone else know it?

"Physicians must stand at the helm of medical care."

About the same time that the accreditation article appeared, I, like most of my colleagues, was sitting down with an office manager to review the new OSHA regulations on bloodborne pathogens. Physicians certainly support appropriate safety measures and quality standards for medical tests and procedures, but most feel that regulations such as these serve to make primary care less and less attractive.

A young physician carrying medical school debts already makes a difficult decision when choosing a lower-paying primary care practice. And the difficulty increases if that student chooses to practice alone. Excessive regulations, such as OSHA's, can do much to further discourage the selection of primary care specialties, especially when applied to small offices where the cost and extent of the measures far exceed the probability of an incident of significant exposure.



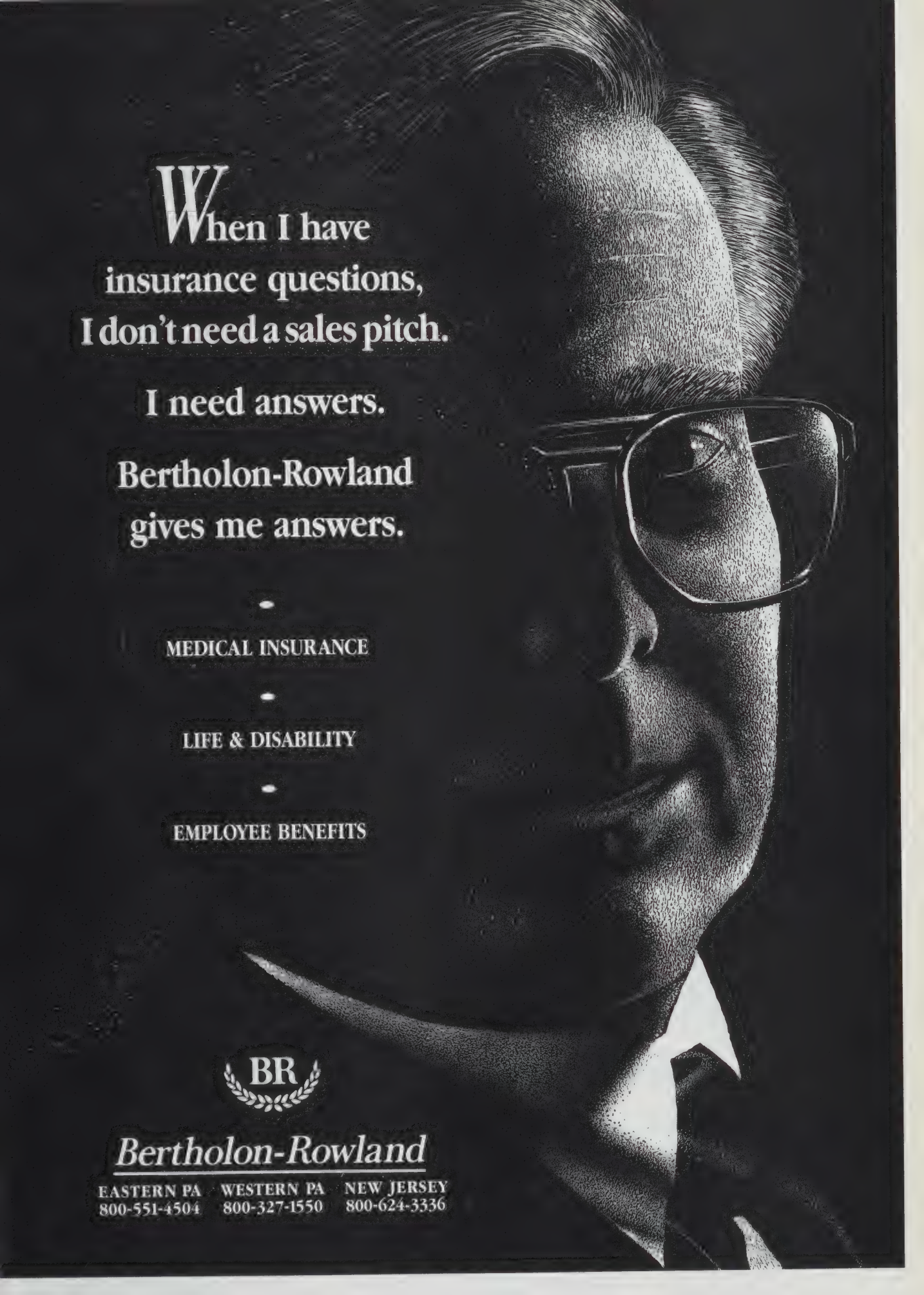
Certainly, we understand that a practitioner who chooses primary practice is in a small business, and the physician must understand that up front. As in any private enterprise, there can be no substitute for responsible business practices. We in the medical community can use our own resources and organizations to provide economic advice and practice management training to our young colleagues who embark on a primary care practice. But economic factors beyond our control, such as burdensome costs associated with implementation of excessive regulations, may prevent our efforts from bearing fruit.

It is not in either the patient's best interest nor the medical profession's best interest to have the basic primary care physician network deteriorate, only to be replaced by non-physician practitioners. First and foremost, there are quality concerns. But there are cost concerns, as well. Problems that could be handled at a good primary physician level would instead very likely be referred to a high-tech medical center unnecessarily.

The best thing for our patients is the best thing for our health care system: ensuring a sufficient number of well-trained primary care physicians. We must find ways of taking our insights to the decision-makers who pass bills and promulgate rules that affect our day-to-day practice of medicine. We have already had many successes, large and small, with such issues as RBRVS and clinical laboratory regulations. These examples show what it takes for physicians to succeed in such matters: informed, unified effort. Our strength in dealing with legislators, third-party payors, and others depends on our strength in numbers.

Physicians must become and remain informed about the laws and policies that will affect them; and they must dedicate time, even five minutes a week, to personal contact with legislators and opinion leaders. At the same time, the Society will continue to review and act on all matters that affect the practice of medicine.

Physicians must stand at the helm of medical care. It is vital that all the spectrum of medical care remain under physician direction.


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LETTERS TO THE EDITOR

IN PRAISE OF "MALPRACTICE PROPHYLAXIS"

I was delighted to read Dr. George J. Paul's article, "Let's Practice Malpractice Prophylaxis," in the April issue, especially since he is a friend and colleague. Dr. Paul neglected to mention the most important maxim, i.e., "Listen to what your patient is saying." He did say the heart of prophylaxis is communication but did not emphasize the importance of hearing what the patient is trying to tell you. I dare say that if this maxim were strictly practiced, nine out of 10 times, a deficient chart would be of secondary importance because there would be no need for an attorney to read it.

Jack E. Cole, MD
Bethlehem

PAINTING WITH TOO BROAD A BRUSH?

I am an avid reader of your excellent publication, PENNSYLVANIA MEDICINE. However, I must take exception to your editorial called "Law and Medicine: Where the Similarity Ends" [by John W. Mills, MD, March 1992].

It seems to me you are painting with too broad a brush. Just as we all abhor general slurs based on gender, race, or other similar categories, I think we should equally abhor denegrating an entire profession. As both a physician for many, many years and a lawyer for the last five, I can tell you quite frankly that the huge majority of attorneys that I have met and worked with in my career have been very fine people. There is no question but that there is a small minority who do not have any scruples or ethics, and it is a shame that these people are the ones who conjure up the worst images.

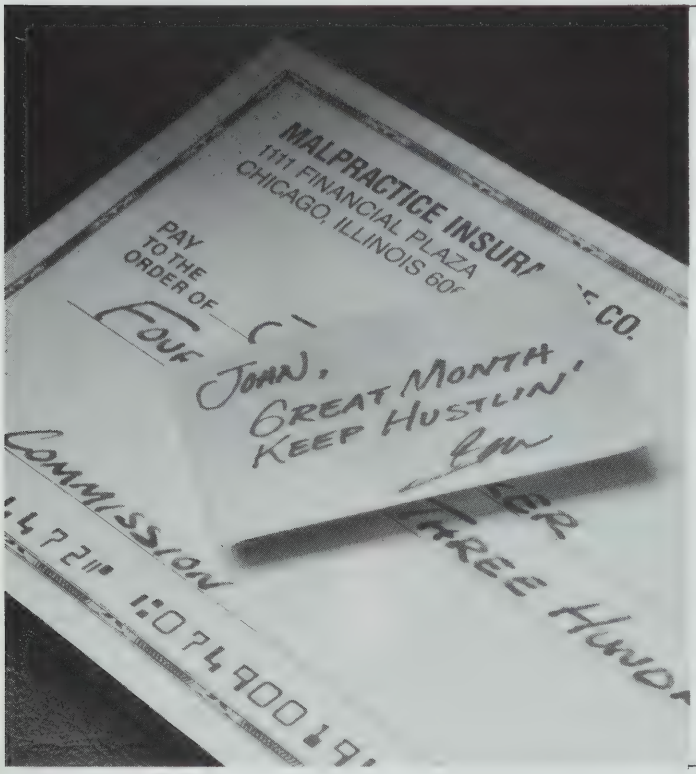
As to advertising, one can only open up any yellow pages directory and see the dozens upon dozens of advertisements by physicians, often in poor taste. Yet, we would not even think about categorizing all physicians based on a few "bad apples."

I fear that this type of editorial just adds to the paranoia and distrust which seems to grow continually between the two professions. It is time to heal and bridge the gap, rather than to further widen it. There are fine and respectable practitioners of both professions, and, in my opinion, they are certainly in the majority. Let's try emphasizing this for a change rather than adding to the anti-legal hysteria that exists today among many medical practitioners.

Andrew Newman, MD, JD
Bala-Cynwyd

Medical Editor's Note: Your comments are not without merit. Both professions do suffer from caricature generalizations. However, my comments relate to the maelstrom in which the medical profession finds itself, especially in Pennsylvania. We have been totally "outgunned" by the legislature and the courts (both controlled by the legal profession) in trying to get significant tort reform via controls that have been legislated in many other states. In addition, our practice of medicine in the Medicare arena is shackled by decreasing fees, more paperwork, and mandated efficiency at the expense of patient communication and risk management. Here Congress runs the show—again, the legislative branch. It should be no surprise to anyone that there is distrust and paranoia on our part. I don't like it, but I have to tell it the way I see it.

John W. Mills, MD
Medical Editor

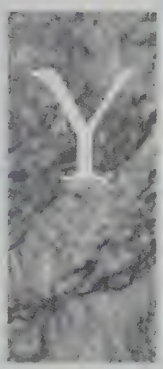


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Understanding Advance Directives and Amendments to Guardianship Law

Susan M. Weber, Esq.

In April, Pennsylvania became one of the last states in the country to statutorily recognize living wills. In addition, Pennsylvania guardianship statutes have been amended. This article describes those changes and informs physicians of their responsibilities when patients have executed living wills or when guardians have been appointed by the courts.

This article will describe the provisions of the Advance Directive for Health Care Act, while a future article will discuss the Durable Power of Attorney for health care.

On April 16, 1992, Governor Casey signed the Advance Directive for Health Care Act ("the Act"), which provides statutory authority in Pennsylvania for living wills, into law. The Act is a result of many years' work by representatives of various statewide constituencies. (See "State Code Remains Silent on Living Will Law Despite Cruzan Case," PENNSYLVANIA MEDICINE, January, 1991.)

Physicians should be aware of the interrelationship between the provisions of the Act and their medical practice. While the new law may not alter the way many physicians relate to their patients, others may find they must develop a new type of partnership with their patients to deal with certain health care decisions.

The federal Patient Self-Determination Act, which became effective December 1, 1991, requires institutional health care providers to inform adult patients of their rights under state law to make health care decisions at the end of life, including the right to accept or reject treatment and the right to execute advance directives. (See "Implementation of Self-Determination Act Begins," PENNSYLVANIA MEDICINE, November, 1991.) Until now, Pennsylvania statutory law has addressed only the ability to nominate a representative under a Durable Power of Attorney for health care. Since the passage of the Advance Directive for Health Care Act, physicians will likely see several types of documents in which patients will make their wishes known.

Under the Act, any person who is at least 18 years of age, or who has graduated from high school or has married, may execute an advance directive related to the "initiation, continuation, withholding, or withdrawal of life-sustaining treatment." The directive must be witnessed by two adults but need not be notarized. Although the Act includes a model directive, declarants may utilize other forms if they wish.

The model directive allows the declarant to set forth choices through a menu format, which includes cardiac resuscitation, ventilation, dialysis, nutrition and hydration, blood transfusions, surgery, invasive diagnostic testing, and the prescription of antibiotics. A declarant may also designate a proxy or surrogate who would make treatment decisions for the declarant.

An advance directive does not automatically go into effect after it has been signed by the declarant. An advance directive becomes operative only after the treating physician receives the directive and determines in writing that the declarant is incompetent *and* in a terminal condition or a state of permanent unconsciousness. The statute defines "incompetent" as the "lack of sufficient capacity for a person to make or communicate decisions concerning himself." Permanent unconsciousness includes both "persistent vegetative state" and "irreversible coma," and is defined as a condition diagnosed to a reasonable medical certainty, under currently accepted medical standards, "as total and irreversible loss of consciousness and capacity for interaction with the environment." A "terminal condition" is defined as an "incurable and irreversible medical condition in an advanced state...which will, in the opinion of the attending physician,...result in death regardless of the continued application of life-sustaining treatment." The standard for the physician's determination that a patient suffers from a terminal condition is also that of a reasonable medical certainty.

The physician must obtain written con-

Ms. Weber is assistant general counsel for the Pennsylvania Medical Society.

One to One.

One to One is a series that invites physicians to ask questions about Pennsylvania Blue Shield. We've designed One to One to be another open line of communication between physicians and Blue Shield. Our goal is to give you the opportunity to ask questions — and to give us the chance to provide more physicians with information about both our Private Business and Medicare operations.

Your questions will be addressed by Joseph A. Ricci, M.D., Blue Shield's Vice President of Medical Affairs. In the first several installments of One to One, Dr. Ricci answers some of the most commonly asked questions about Blue Shield.

If you have a question, please write Dr. Ricci at: Pennsylvania Blue Shield, P.O. Box 890089, Camp Hill, PA 17089.

What is a Medicare Participating Physician?

A Medicare Participating Physician is a provider who has entered into an agreement with the Health Care Financing Administration (HCFA) to accept assignment for all the services he or she provides Medicare patients. The contracts usually run for a 12-month period and are automatically renewed unless a provider requests that it be terminated. In these cases, the provider must give written notice to all Medicare carriers with whom he or she has filed agreements. Providers may only drop their Participating status at the end of their agreements.

What happens when a physician accepts assignment?

When a provider accepts assignment, he or she agrees to accept Medicare's approved allowance as full payment for a service supplied to a Medicare patient. Even non-participating physicians may accept assignment for their Medicare patients on a case by case basis. Medicare will view each claim as a separate contract.

Are there any cases where a non-participating physician must accept assignment?

Yes. Non-participating physicians must accept assignment for all clinical laboratory services, including venipuncture/specimen collection and clinical laboratory fees. In addition, HCFA regulations say all providers must accept assignment for services provided to a Medicare patient who is enrolled in Medicaid.

And, clinical psychologists, physicians' assistants, certified registered nurse anesthetists, clinical social workers, nurse practitioners, clinical nurse specialists and nurse midwives are required to accept assignment on all Medicare claims.

What are the advantages of being a Medicare Participating Provider?

HCFA provides the following incentives to encourage physicians to participate:

- ***Higher fees:*** Fee schedule amounts for Medicare Participating Providers are higher than those for non-participating physicians. In fact, non-participating physicians receive just 95 percent of the fee schedule amount paid to Participating Providers.
- ***Medpard directory:*** Every Medicare carrier publishes a directory — known as the Medicare Participating Physician/Supplier Directory or Medpard — with the name, address and specialty of each Participating Physician who has filed a contract with them. These directories are available to senior citizens and their organizations, to hospitals and to Participating Physicians.
- ***Electronic claims submission:*** Toll free telephone lines are available for Participating Providers to use electronic claims submission — when they file their claims with a personal computer and a modem.
- ***Faster claims turn around:*** Most claims filed by Participating Physicians are processed more quickly than those submitted by non-participating providers.
- ***Medigap piggybacking:*** Medicare carriers forward claims to Medigap insurers, when the claims are filed by a Participating Provider.
- ***Hospital referrals:*** Hospital personnel, when referring a Medicare patient to a non-participating physician, must also, when practical, identify a qualified Participating Physician for the patient.

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currence in the diagnosis of a terminal condition or state of permanent unconsciousness from a second physician. Both physicians must document their diagnoses in writing "without delay." The Act does not define the legislature's intent with regard to the use of the term "without delay."

Although the section of the Act which describes when a declaration becomes operative does not require the second physician's concurrence prior to implementation of a directive, a later section implies that a declaration becomes operative only after the second opinion has been obtained. Therefore, until the Department of Health has promulgated regulations, the cautious physician would obtain a second opinion prior to issuing implementation orders.

If a physician is unable to comply with a patient's directive in good conscience, the Act requires him or her to inform the patient and make "every reasonable effort" to assist in the transfer of the patient to another physician. The Act does not define "every reasonable effort." However, it does provide protection from civil and criminal liability and administrative sanctions for the health care provider who is unable to transfer care and who subsequently renders life-sustaining treatment contrary to the provisions of the directive.

"The most controversial provision of the Act is the pregnancy protection provisions."

The physician can avoid this scenario by arranging for patient transfer in advance of a crisis situation. By discussing advance directives with the patient during routine office visits, the physician can address several issues. First and foremost, the physician demonstrates availability to the patient to answer questions, explain terms, and understand the patient's philosophy concerning end-of-life medical care.

Second, the physician and patient can come to an agreement about the patient's desires for terminal care. Third, if differences are irreconcilable, the physician can explain to the patient the need for transfer of care to a physician who can accommodate the patient's wishes.

The statute forbids discrimination against any health care provider for nonparticipation in the withholding or withdrawal of care, but the provider may be required to document objections in writing. Under the Act, "health care provider" includes any person licensed or certified in Pennsylvania to render health care. The Act includes those recognized under the Emergency Medical Services Act.

The Act authorizes EMS personnel to honor advance directives in the field under (or in) one of the following scenarios. In the first, the EMS personnel must receive an original signed declaration. The personnel then must notify the command physician, who issues orders based upon the directive.

The Act does not indicate how the command physician or the EMS personnel are to verify that a declaration has become operative. Department of Health regulations, which have not yet been issued, should clarify this point.

In the second scenario, the command physician issues orders to EMS personnel pursuant to notification by "the attending physician or other health care provider that a valid and operative directive exists." Therefore, any health care provider, as defined in the Act, may notify the command physician about the existence of a valid, operative directive.

When a patient with a valid, operative directive must be transported by EMS personnel for any reason, the attending physician should notify the command physician prior to transport when possible, so that EMS personnel can honor the directive based upon orders received from the command physician,if need be.

The Act further requires that if any conflicting information exists with respect to a declarant's wishes, EMS personnel are to follow established treatment protocols. Thus, where family members cannot agree even in the presence of a valid and operative declaration, EMS personnel will treat the declarant. It is likely that EMS personnel faced with uncertainty as to whether the declaration has become operative will also treat the declarant.

Health care providers must honor a patient's revocation of a directive. The Act provides for revocation at any time and in any manner, regardless of the patient's physical or mental condition. It also provides for criminal prosecution for anyone who forges, falsifies, defaces, or cancels a directive or who conceals knowledge of the revocation of a directive.

Therefore, regardless of a patient's mental status, a physician faced with a revocation of a directive should issue orders cancelling those which implemented the directive. In addition, the Act requires that a revocation be included in the medical record. A written revocation could be physically included in the record, and a verbal revocation could be documented in the progress notes. A physician notified of a revocation should document all pertinent information received, such as the manner in which the revocation occurred, identification of the person who notified the physician, and the circumstances under which the revocation occurred.

The most controversial provision of the Act is the pregnancy protection provision. If a pregnant woman becomes incompetent *and* either terminally ill or permanently unconscious, she must be maintained on life support until the fetus can be safely delivered irrespective of her written directions to the contrary. No physician is required to perform a pregnancy test, however.

The Act provides three circumstances under which physicians are not required to maintain the life of a pregnant woman. The attending physician and an obstetrician must examine the woman and document to a reasonable medical certainty: first, if life-sustaining treatment, nutrition, and hydration would not permit the development and live birth of the fetus; second, if such treatment would be harmful to the woman; or third, if the treatment would cause her pain which medication could not alleviate. The state is required to pay for treatment costs, but has the right of subrogation against health insurance payments.

Guardianship provisions

The Advance Directive Act was passed as part of Act 24 of 1992, which also contains provisions which amend Pennsylvania guardianship laws. Physicians should understand the general concepts embodied in the guardianship provisions as they relate to the practice of medicine.

Under previous law, once a person had been adjudicated "incompetent," he or she was considered incompetent for all legal purposes, including medical decision making. Amendments now provide for varying levels of "incapacity." The amendments define "incapacitated person" as "an adult whose ability to receive and evaluate information effectively and communicate decisions in any way is impaired to such a significant extent that he is partially or totally unable to manage his financial resources or to meet essential requirements for his physical health and safety." The use of the term "incapacitated" in the guardianship provisions appears to be consistent with the use of the term "incompetent" in the Advance Directive Act, discussed above. Physicians should be aware, however, that only a court can make a determination of incapacity for guardianship purposes.

Act 24 does not address whether a living will would remain in effect in the event a guardian has been appointed, and no case law has yet been developed. It is quite possible that once a guardian has been appointed for health care decisions, the living will would become an advisory document only.

The amendments state a preference for limited guardianship, depending upon the nature and severity of the person's incapacity. Courts are required to fashion individual guardianship orders, tailored to meet the needs of the "partially incapacitated" person. Full guardianship is recommended only when the person is "totally incapacitated." Guardians must encourage participation by the incapacitated person to the maximum extent possible in all decisions which affect the person, and to act on the person's behalf when able.

Thus, physicians will encounter patients who are incapacitated for some purposes but not others. For example, some persons may require guardians for financial purposes but are able to comprehend medical conditions and make personal health care decisions. Partially incapacitated persons retain all legal rights except in those areas in which the court has vested guardians with responsibility. Nevertheless, physicians may experience situations in which persons who are incapacitated for health care decision purposes participate to some extent at the request of the court-appointed guardian.

Unless a court specifically grants certain powers to a guardian, he or she may not make some decisions without court approval. For example, a guardian may not consent to "abortion, sterilization, psychosurgery, electroconvulsive therapy, or removal of a healthy body organ" on behalf of an incapacitated person. Similarly, a guardian may not consent to the participation in an "experimental biomedical or behavioral medical procedure."

The amendments prohibit courts from granting certain powers to a guardian which are governed by other statutes, such as the power to admit the incapacitated person to inpatient psychiatric units or state facilities for the mentally retarded, or to relinquish the person's parental rights.

The statutory amendments discussed in this article require that physicians understand not only patients' wishes concerning medical care, but also their varying decision-making capacities. For the most part, these new requirements will not alter individual physicians' practice of medicine. In certain circumstances, however, some physicians may find that they must develop new and hopefully more satisfying relationships with their patients.

NOTE: A bill is now under consideration in Pennsylvania to change the effectiveness date of the guardianship provisions from June to September 15.

Living Will Brochure Available

The Society has redesigned the brochure "Dignity in Life, Dignity in Death." It is consistent with the Advance Directive for Health Care Act and contains a living will, proxy designation clause, and a wallet card which identifies where an individual's living will can be obtained. Physicians who wish to receive copies of the brochure for patient distribution should contact the Division of Communications and Public Affairs at Society Headquarters in Harrisburg.

LIVING WILL BROCHURE AVAILABLE

"Suppose I'm in an accident. I'm in a coma, on life support. Decisions must be made. Would my family know my choices?"

This is one question your patients may be asking you, now that Pennsylvania has passed the Advance Directive for Health Care Act. As a physician, you are responsible to help them with the "living will" process and their decisions. Are you prepared to do so? Why not let your State Society help?

The Pennsylvania Medical Society has revised its living will brochure to reflect the Commonwealth's new act. Designed for your patients, the brochure:

- describes how to prepare a living will;
- includes a model living will;
- answers questions, such as "What do I do with my living will?" and "What if I change my mind?"; and
- provides a wallet card which, when completed, serves as notification that a person has signed an advance directive and indicates where a copy can be obtained.

Physicians: By helping patients prepare a living will, you can help them communicate their views about artificial support to you and their family members. In a sense, the document speaks for them when they can no longer speak for themselves.

How to order

Physicians can order brochures by using the order form below. State Society members may receive up to 100 copies of the brochure free-of-charge upon request; printing and shipping costs will be charged for quantities of more than 100 brochures. The general public may obtain individual copies free-of-charge by sending a stamped, self-addressed envelope to the Society with a note requesting one brochure. Larger quantities may be purchased by nonmembers upon request.

For more information, call the Pennsylvania Medical Society Division of Communications and Public Affairs at (717) 558-7750 or 1-800-228-7823.

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Plans Proceed to Publish Physician-Specific Data

John A. Malcolm Jr., MD

Physicians should be aware that the release of physician-specific information by the Pennsylvania Health Care Cost Containment Council (PHC4) may have a significant impact on decisions made by patients or potential patients. This article, which outlines PHC4's proposed Research Plan about coronary artery bypass graft (CABG) surgery and related issues, is a follow-up to "First Report Card for Physicians Due This Summer" [PENNSYLVANIA MEDICINE, May 1992].

The Pennsylvania Health Care Cost Containment Council (PHC4) released on April 22 its proposed Research Plan, which details in varying depth the methodologies and techniques to be used by the council in selecting and utilizing risk-predictive factors for coronary artery bypass graft (CABG) surgery patients. The Research Plan was reviewed by the State Society's Task Force on Health Care Cost Containment, as well as independent statisticians and leadership of the Pennsylvania Association for Thoracic Surgery. Comments were also offered by several members of the newly formed PHC4 Technical Advisory Group—three of whom are MDs.

The comment period for the Research Plan ended May 15. A variety of significant points concerning statistical methodologies, validation procedures, epidemiology, etc., were raised by reviewers and will be addressed when the final version of the Research Plan is released. The risk-adjusted mortality/morbidity ranges for hospitals and physicians as developed from the Research Plan are due for review this month.

The following risk-adjustment factors for predicting "expected patient deaths" (mortality) are proposed by PHC4's Research Plan:

- patient demographic factors—age and sex;
- admission clinical factors—admission severity, elective or urgent admission, urgent transfer from another hospital, surgery performed by third day, presence of mechanical device aiding heart function, and failed angioplasty;
- pre-admission clinical factors—comorbid conditions, such as recent acute myocardial infarction, congestive heart failure, diabetes mellitus requiring insulin, hypertension, previous CABG procedure, or unstable angina; and
- anatomical disease factors—the presence of multiple coronary vessel disease.

The list of risk-predictive factors for "medically unstable" (PHC4 surrogate for major morbidity) is the same as mortality less "surgery performed by third day." Similar but not identical risk-predictive factors were used in previously published CABG surgery reports in New York and New Jersey, although greater emphasis was placed on left ventricular function and/or functional cardiac classification by those states. The methodology to be used in Pennsylvania does not capture functional cardiac classification data.

The PHC4 report on CABG surgery will have several sections, including general statewide statistics, specific hospital statistics, and specific physician/physician practice group statistics. The most voluminous portions of the report will cover hospitals, largely because charge data and individual risk factor comparative data will be reported only for hospitals. Several bar graphs detailing comparative case volumes and average charges will be included displaying very substantial ranges between the highest and lowest hospitals. Hospital administrative personnel and physician staff will likely be expected to meaningfully discuss this data, including charges.

For physicians, the most poignant part of the report will be the physician and physician practice group data. Originally the PHC4 staff indicated that mortality/medically unstable data would be reported only for hospitals and physician practice groups. However, in May they indicated a significant change by ten-

Dr. Malcolm, a pathologist from Sunbury, is chairman of the Society's Task Force on Health Care Cost Containment and a member of the Joint Committee on Health Care Data of the State Society, the Pennsylvania Osteopathic Medical Association, and the Hospital Association of Pennsylvania.

tatively considering inclusion in the report of statistics for individual operating surgeons doing more than 29 cases in 1990.

One factor entering into the decision to consider publishing individual physician statistics was the finding that one quarter of the 205 operating surgeons doing CABG surgery in Pennsylvania were independent practitioners. Hence, they would be excluded if published mortality/medically unstable statistics were limited to physician practice groups of more than one. Conversely, if independent surgeon practitioners were considered the same as a practice group, their mortality/medically unstable statistics would be published, while individual surgeons in large groups would not have their statistics published.

This development has raised additional concerns—addressed in recent newsletters of the Joint Committee on Health Care Data—by the task force, joint committee, and cardiovascular surgeons. In order to know the issues and their current status, physicians should contact their Hospital Medical Staff Section (HMSS) representative or medical staff president for copies of the newsletters.

The recommended final draft report format by the PHC4 Data Committee lists physician practice groups and their component cardiovascular surgeon members under the hospitals where they performed CABG surgery, and surgeons performing CABG surgery at more than one hospital are denoted. Hospitals in which CABG surgery is performed are grouped two ways: 1) by geographic location in Pennsylvania—eastern, central, or western; and 2) over the objections of physicians, by whether their 1990 mortality statistics are greater than, the same as, or less than predicted by the methodologies proposed in the Research Plan.

Hospitals, physician practice groups, and physicians may comment on *their* statistics prior to the release of the report. All such comments will be published and sent with the report to involved hospitals and physician practice groups to coincide with the date of public release of the report. Comments will also be distributed with copies of the report to the media at the official press conference announcing the public release of the report. The joint committee has published some recommendations for surgeons and their practice groups about the comment procedure in the May issue of its newsletter.

Several hospitals and their cardiovascular surgeon groups have filed grievance procedures with PHC4 about the pending report; such actions continue. The Society will publish updates on those actions and the CABG surgery report in future issues of its publications. In the meantime, "it ain't over 'til its over!"

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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatic. It may have activity as an aphrodisiac.

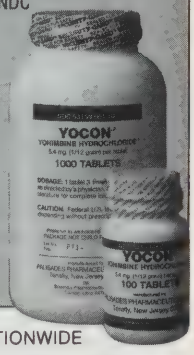
Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.



References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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SOCIETY ADDRESSING BLUE CHOICE CONCERNS

The Society has been working with the Pennsylvania Department of Health (DOH) to resolve a number of the Society's concerns with Pennsylvania Blue Shield's new Blue Choice program.

Blue Choice is essentially a preferred provider organization (PPO) with two gatekeeper options. Under the lock-in option, the enrollee is locked into one gatekeeper for primary care and referrals. Under the passive option (or panel approach), the enrollee may use any participating gatekeeper.

DOH has approved the Blue Choice provider contracts and the passive option; however, they have not yet approved the lock-in option. Mellon Bank and Duquesne Power and Light, the first two companies to enroll with Blue Choice, switched their coverage to the Blue Choice passive option as of January 1 of this year.

Last year, the Society filed a formal complaint with DOH protesting Blue Shield's solicitation of physicians to sign provider contracts before the contracts had even been approved. DOH has since directed Blue Shield to obtain new contract signatures from primary care providers (PCPs)—the gatekeepers. Blue Shield has also agreed to provide a window period for specialists to cancel their participation.

DOH has also been responsive to other Society concerns. Major successes to date include:

- The lock-in gatekeeper option must meet the same quality of care oversight standards as a health maintenance organization (HMO), including an external quality audit. Blue Shield has volunteered to apply these same standards to the passive gatekeeper option.
- The lock-in option must meet the same accessibility and availability standards as an HMO. Blue Shield has volunteered to apply these same standards to the passive option.
- Blue Choice must pay its participating physicians on a fee-for-service basis and cannot tie their reimbursement to their utilization—i.e., holdbacks, bonuses, and creeping capitation are prohibited.

The Society and DOH are also closely reviewing the Blue Choice "efficiency" credentialing process. As currently proposed, physicians will be assigned points based upon utilization and cost profiles, and be excluded if their point totals exceed a designated cut-off. While excluded physicians are provided a limited opportunity to appeal their exclusion, the current proposal does not require Blue Shield to prove excluded physicians were inefficient through a case-by-case review of their care.

The Society will continue to press for resolution of the remaining concerns and keep its membership advised of new developments. Future Society publications will outline the terms of PCP and specialist provider contracts. In the meantime, Society members with questions about Blue Choice may contact the Council on Medical Economics staff at 1-800-228-7823.

HCFA FURTHER EXTENDS USE OF "OLD" 1500 FORM

As a result of a joint lobbying effort of the State Society and the AMA, the Health Care Financing Administration (HCFA) has extended the deadline for accepting the old (1-84) edition of the HCFA 1500 form. Previously, HCFA announced that as of May 1, 1992, it would only accept the new (12-90) form. HCFA has now agreed to a 60-day grace period.

Both editions of the HCFA 1500 form will be accepted through June 30, 1992; and claims received by Pennsylvania Blue Shield, Pennsylvania's Medicare carrier, on or after July 1, 1992, must be on the new (12-90) edition. When using the old (1-84) form, the completion requirements applicable to the old edition must be used. For example, new place-of-service (POS) codes should not be used on the old (1-84) edition. When using the new (12-90) edition, all requirements applicable to the new edition, such as the new POS codes, must be used. Also, HCFA has said that the 60-day grace period does not apply to "superbills."

The Society and the AMA had asked for the grace period because physicians who electronically print their claims were encountering problems complying by May 1.

MEDIGAP "PSYCHIATRIC" PROVISIONS REVIEWED

The Society in April provided to the state Insurance Department comments about a proposed Medicare Supplemental Insurance regulation published in the March 28 *Pennsylvania Bulletin*. According to the Society, "the proposed regulation will create confusion regarding the extent to which Medigap insurers are obligated to pay the copayment for outpatient psychiatric services."

As a general rule, Medicare Part B pays 80 percent of the Medicare allowance after the deductible has been satisfied; the beneficiary is responsible for the remaining 20 percent copayment. The problem stems from the unique copayment applicable to outpatient psychiatric services which can equal up to 50 percent of the Medicare allowance.

In the past, it was not always clear whether a Medigap policy was required to pay the full copayment; and even in cases where the policy clearly required payment of the full copayment, some insurers did not pay the full amount due.

In an effort to address current confusion—caused by regulations—the State Society, in its comments, recommended that the Insurance Department revise the proposed regulations to clearly state that a Medigap insurer must pay the full copayment (which can reach 50 percent of the allowance) in the case of outpatient psychiatric services.

The American Psychiatric Association (APA) is working with the National Association of Insurance Commissioners to clarify the situation. The Society is coordinating with the APA's Pennsylvania chapter to pursue further clarification of the copayment requirements.

HMO RULE ADDRESSES SOCIETY CONCERNS

The Independent Regulatory Review Commission (IRRC) in mid-April approved a final rule, relating to health maintenance organizations (HMOs), published by the Insurance Department in March. The rule incorporates many of the State Society's original concerns with the proposed regulation.

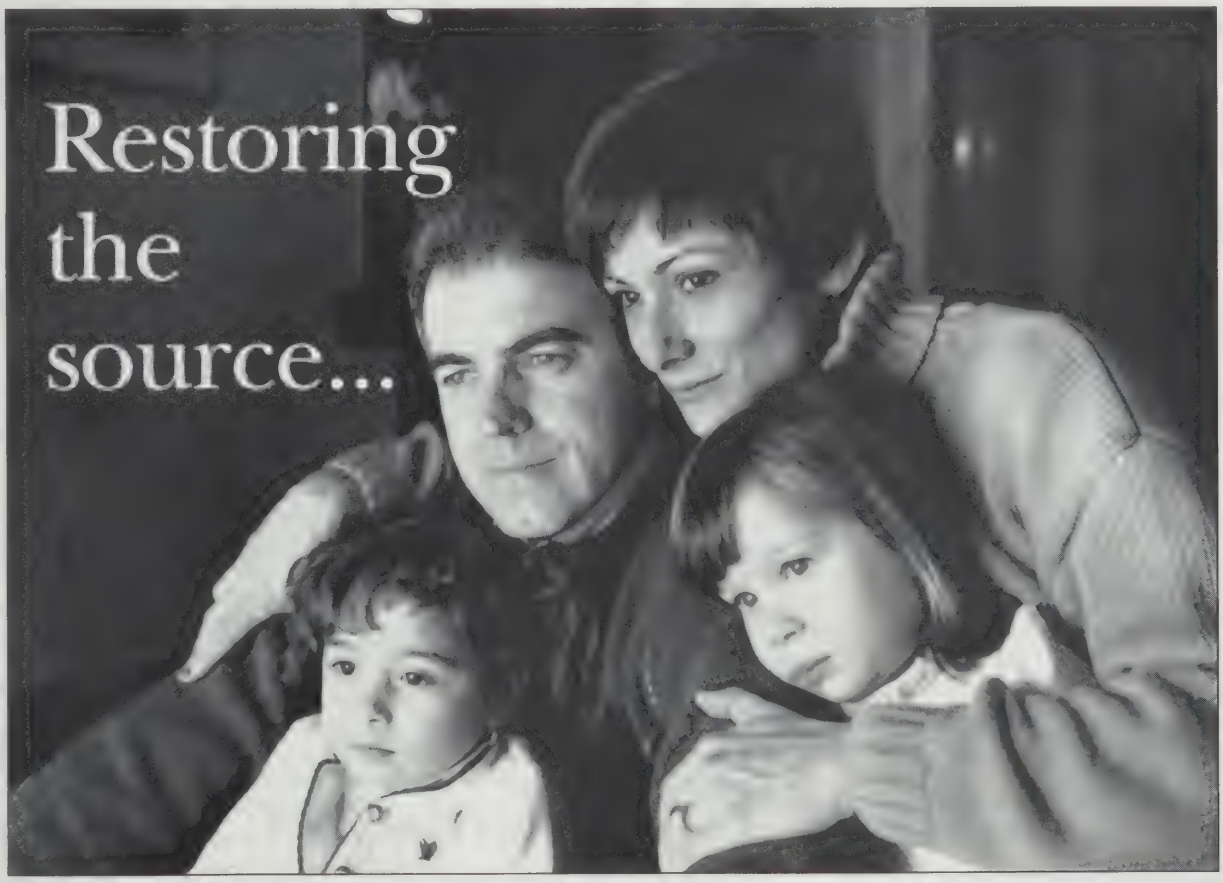
The new regulation, which went into effect immediately after IRRC approval, includes several consumer-protection measures designed to strengthen the financial condition of HMOs and protect subscribers of insolvent HMOs. Specifically, it requires existing licensed HMOs

which do business in Pennsylvania to increase their capitalization from $100,000 to the new requirement of $1 million. New HMOs will be required to have $1.5 million in capital prior to receiving a license. The regulation also requires:

- each HMO to deposit $100,000 with the state Insurance Department to cover administrative costs in the event of insolvency;
- each HMO to provide subscribers with benefits for the period for which premiums have been paid in the event of insolvency;
- each HMO contract to include a "hold harmless" provision which states that subscribers cannot be held responsible for health care bills in the event of insolvency; and
- insurance companies attempting to pick up the business of an insolvent HMO to offer subscribers the same benefits at the same rate charged by the HMO.

Among the Society's concerns was the need for clarification of the "hold harmless" language in the proposed regulation. The final regulation includes such clarification, making it clear that physicians can collect co-payments and deductibles due from the patient. In addition, the department confirmed the Society's concern that proposed "continuation of benefits" language cut off a provider's obligation at the date of the patient's discharge or the expiration of the premium period, whichever occurs earlier.

One issue which the Society protested still remains: the order of distribution of assets. The Society commented that physicians should be placed ahead of general creditors in the order of distribution of assets. However, the department contended that priorities for distribution are mandated by statute rather than regulation, and that they did not have the authority to change the order.



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SENATE TO VOTE ON WORKERS' COMP

The full Senate, at press time, had not yet acted on a bill to reform the state's workers' compensation fees using the federal workers' compensation fee schedule as its base. As the expected vote neared, Society leaders, who oppose linking workers' compensation reform to Medicare, were brought onto the hill to keep the pressure on the legislature.

House Bill 2140 originally passed the House of Representatives capping workers' compensation reimbursements using 113 percent of Medicare as a fee schedule. Following several months of intensive lobbying from health care providers, the bill was amended (9-2) by the Senate Labor and Industry Committee in early April, replacing Medicare with a cap of 80 percent of the federal Office of Workers' Compensation Programs (OWCP) fee schedule. The amended bill was then reported out of the Senate Appropriations Committee by a 15-1 vote.

In a May 4 press conference, Governor Robert P. Casey threatened to veto any workers' compensation bill which reached his desk without the Medicare link. He claimed the cost of the "doctor/hospital plan" was 60 percent more per procedure than 113 percent of Medicare; and he referred to a report of the Pennsylvania Compensation Rating Bureau (PCRB) which estimated that using the federal fee schedule would *increase* workers' compensation medical costs by 15 percent. His plan, Casey asserted, would *save* an estimated 25 percent.

The Society responded immediately, challenging the validity of the PCRB data and communicating the Society's concerns about the potential impact excessive cuts would have on the health care system. The Society distributed a cost analysis by Ernst and Young estimating the Society's proposal would save a minimum 19 percent in payments to non-hospital providers and an average 23.5 percent in annual workers' compensation payments to hospitals. As the Senate vote neared, the Society and the Hospital Association of Pennsylvania (HAP) provided copies of the analysis to members of the legislature.

State Society President Robert N. Moyers, MD, in a letter to Governor Casey, further addressed the issue: "Data being provided by private insurers, which have a $1/2 billion stake in the issue, are suspect...for example, in one recent [meeting]...it became absolutely clear that the insurer's data were terribly flawed and totally unusable for use in making any statewide comparisons or projections." Fearing the state may be using flawed data in its projections, the Society asked Casey to release data on the State Workmen's Insurance Fund. Two prior requests for the information were unanswered.

On the day following the governor's press conference, the Pennsylvania Chamber of Business and Industry held a "special event" on workers' compensation in Harrisburg. The intent of the program was to allow members of the chamber, in an attempt to develop a position on the medical alternatives of a workers' compensation system, to hear arguments from proponents of the two leading proposals: the federal workers' compensation schedule and the governor's Medicare schedule. Members of the panel included representatives of the Society, HAP, the insurance industry, small business, the PCRB, and the legislature. The program was well-attended by Pennsylvania employers. According to Society representatives in attendance, "Business is sympathetic to the medical community, but it needs savings."

SOCIETY COMMENTS ON SELF-DETERMINATION RULE

On behalf of the State Society, President Robert N. Moyers, MD, in a letter to the Health Care Financing Administration (HCFA), commented about the interim final rule on advance directives published in the March 6 *Federal Register*.

The regulations were promulgated by the Patient Self-Determination Act (PSDA), established by Congress as part of the Omnibus Budget Reconciliation Act of 1990 (OBRA '90). The PSDA became effective on December 1, 1991, and requires certain Medicare- or Medicaid-reimbursed health care entities to provide adult individuals with information about their right to direct and participate in decisions concerning their health care.

The Society stated three concerns in the letter and recommended, as clarifying language, that the final regulations include: 1) a definition of "adult individuals" which would include, for example, minors permitted under state law to make decisions concerning their medical care; 2) allowances for alterations to the written policy explaining the provider's conscientious objections to advance directive provisions based upon case-by-case determinations of issues not previously considered by faculty; and 3) a 60-day compliance time to allow for appropriate changes in provider policies and procedures.

After considering comments and recommendations from the Society and other responding organizations, HCFA will work to finalize the regulations.

"NEW PHYSICIAN" BILL FOR U.S. INTRODUCED

New efforts to repeal the inequitable Medicare payments for "new physicians" have been introduced in the U.S. Senate (S.2362) by Senator John McCain (R-Arizona) and in the House (H.R. 4507) by Representative Edolphus Towns (D-New York).

Presently, Medicare pays physicians in their first year of practice 80 percent of the amount determined by the resource based relative value scale (RBRVS) formula, while physicians in their second year receive 85 percent, in their third year receive 90 percent, and in their fourth year receive 95 percent.

The new legislation asks for equal payment to all physicians and contains budget neutrality language which directs the Secretary of Health and Human Services to make reductions in aggregate Medicare payments to offset the increased spending.

State Society trustees voted to support all legislative activity to help resolve this inequity and has sent their sentiments for strong support to the AMA. Now is the time for physicians to write to their U.S. senators and representatives in support of these budget-neutral proposals.

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Health Views from the Senate: Part Two

Maria T. Montesano
Assistant Managing Editor



Senator Dawida is a Democrat representing Pennsylvania's 43rd District, including part of Allegheny County. He is currently serving his first term in the Senate and is seeking re-election this year. Senator Dawida is minority chairman of the Finance Committee, and a member of the following committees: Public Health and Welfare, Banking and Industry, and Urban Affairs and Housing.

This interview was conducted by Miss Montesano, in cooperation with the State Society's Department of Governmental Affairs Division of Legislative Affairs, Larry L. Light, director.

In this second of three interviews with members of the general assembly, Senator Michael M. Dawida talks about the Clean Air Act, living wills, and how physicians can be more involved in the political process.

Question: *Pennsylvania has some restrictions on smoking in public. In relation to that, I have a three-part question for you. First, how difficult was it for Pennsylvania to get where it is? Second, what do you think is doable? And third, where would you like Pennsylvania to be in the future?*

Senator Dawida: It took almost 10 years for the state to enact any meaningful restrictions on smoking. It was extraordinarily difficult, because the tobacco institute is devoted to [opposition to] the issue, and the groups that are for it, such as medical doctors, are interested in a broader range of issues. The tobacco institute has a lot of money and a very single-minded interest. It's always hard to beat someone who has a single-minded interest; it's easier to defeat things than it is to pass them in our legislative process.

[After passage of the Clean Air Act,] I wanted to sit back for a couple years, let it digest, and get people used to a new way of living. What we essentially did was change a presumption in people's minds. The presumption always was, "You can smoke wherever you want; and if you want to breathe clean air, you've got to find it." We're trying to get the public to say, "Clean air is a right, and you smoke where we tell you to."

Fewer and fewer adults are smoking; in the future, [we'll have] a much broader public base with a much clearer understanding of what smoking does to you both directly and indirectly. I hope to go further...to expand on where we are and to make the rules and regulations much tougher.

Question: *Linked to that issue is medical liability reform. What are your thoughts on such reform?*

Senator Dawida: The public needs to understand that there's a trade off [with medical liability]: the higher malpractice rates you have, the more likely costs are going to go up for medical care because that doctor has to pass that cost on, some way, some how.

It is absolutely appropriate if somebody is harmed by a doctor that the doctor pays for that person's suffering. The question is, "At what point are doctors at fault?" We have developed a system that is harsher and comes close to saying, "You're at fault because you are a doctor," rather than "because you did something wrong." We need to change that system; we need to lower medical costs.

Question: *Let's turn to the living will bill. What were your thoughts on the bill, and what was the hold-up?*

Senator Dawida: I was one of the people most *for* living wills. The hold-up was clearly the pro-life groups who felt that pregnant women should not be allowed to have a living will. That is a very emotional issue which has almost nothing to do with living wills, [but] these groups are respected and powerful and were able to hold up the process while their concerns were reviewed.

The issue of nutrition and hydration was the first difficult hurdle. At what point is it appropriate to remove that? Well, "not too often" is the answer to that. The easier question, although still a very painful and difficult one, was at what point do you take people off machines? That's where you need instruction from the person artificially sustaining life. Most people agreed with that, but it's still tough because you're talking about life and then death.

Finally, all those obstacles were removed, and it came down to one obstacle—the pregnant woman. This probably won't even come up four or five times a year. But because it's such an emotional issue—because we've allowed abortion to become such a central, political battle—*it* became the battle instead of what was going to be

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"It's a tenuous idea to require hospitals to do something that by law may be illegal in Pennsylvania. Technology has created a whole set of problems that didn't used to exist."

helpful to a couple million senior citizens who unanimously are for it.

The compromise is unsatisfactory to the pro-choice advocates, but...they had to take it...We were one of the last states—I think the next to last—to pass a living will bill, even though there are federal court orders that have hospitals giving this to everybody. It's a tenuous idea to require hospitals to do something that by law may be illegal in Pennsylvania. Technology has created a whole set of problems that didn't used to exist.

Question: *Are there any other health issues you would like to talk about?*

Senator Dawida: Public health in general needs revitalized, and that's an issue we all have to face. Within three to five years, if we haven't settled our problems on how to give people access to health care and settled some of our more pressing public health issues, we're going to have a revolution...with legislature or the federal government saying, "This is the way it's going to be." Doctors aren't going to like it; hospitals aren't going to like it; the public's only going to like it to some degree—but because our public health policies are thought to not be working, we're going to have to move.

Question: *What is your view on how physicians can best get involved in the political process?*

Senator Dawida: I think doctors have failed in a number of ways, some their fault and some maybe not their fault. The first and the most important is that they all live in the same neighborhoods...That is different than the doctors of just two decades ago who used to live in *every* neighborhood...We had Doc Sexauer in my neighborhood...He was the kind of guy that everybody in the community respected. You went to his house to get his service...and if he was *for* something, I'd be inclined to be for it simply because I know he had the welfare of that community at heart.

Those people don't exist anymore; all the doctors in my senatorial district live in one neighborhood. The difficulty of that problem, of course, is that you can't tell people where to live, and I am not suggesting that we should. It does, however, make involvement more difficult, and getting involved is what this is all about. So they [physicians] have to start getting involved in a more direct way, or this revolution that I talked about is going to happen *to* them.

Question: *Do you hear from the physicians in your senatorial district?*

Senator Dawida: I didn't until very recently. This workers' comp issue is the first time I've seen genuine, "real-live" doctors talking to me in a real way; talking about the issue, what it meant to them, how they needed to serve these people, and so on. It was the first time I'd seen them in 14 years.

Question: *Do you think that will continue?*

Senator Dawida: I would guess, because if it doesn't, their role in our society will change. To give you a real good example, doctors are not treated in this country the way they are everywhere else. [In other countries] they have some social respect, but they don't get the financial rewards that are so evident in this country. That should be a warning that there are other ways to do business. Maybe not better in the long run, but the public is angry at what they perceive as not getting the proper service, paying too much money, not having enough access.

In my district there are 52,000 senior citizens registered to vote. Now, I found 20 doctors. There's no contest—52,000 senior citizens against 20 doctors? Who do you think I should vote for?

Doctors must become much more involved in a personal way. Lobbyists can do a lot of things, but one of the most important things doctors can do is provide information on how things can be best done. They're the experts; they have to get involved in the grassroots in their communities and the political world...[and] the way to get involved is to *get involved*, not just sit on the sidelines.

Question: *And I'm assuming, not just through letter writing?*

Senator Dawida: Particularly not just through letter writing where their secretary types what is written for all of them by your organization. There's some value to that, but that's not the whole ballgame. The ballgame is to get to know, first of all, *who* your legislator is, and maybe personally become his or her expert.

The [state] budget is almost 5,000 line items, each one representing a different issue. I admit to maybe knowing 300-500 issues really well, but I've got 5,000 issues... A doctor who gets to be well-respected by his or her legislator can really make policy or help move policy just by being that person's friend or at least advisor. That can really happen if doctors get involved.

NEXT MONTH

Look for an interview with Representative Elinor Z. Taylor.

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An Update on Lyme Disease in Pennsylvania

Dale Tavris, MD, MPH

With incidences of Lyme Disease increasing annually throughout the Commonwealth, physicians need to be reminded of its diagnosis, transmission, and control.

When Lyme Disease first became reportable in Pennsylvania in 1987, 29 cases were reported. That number has risen every year since, with 271 in 1988, 668 in 1989, 767 in 1990, and 922 reported so far with disease onset in 1991. Pennsylvania's total of 2,733 reported cases is fifth in the U.S., behind New York, Connecticut, New Jersey, and Wisconsin.

The highest incidence of Lyme Disease in Pennsylvania has occurred in the southeast and the northwest around Elk County. Of total reported cases in Pennsylvania, the three contiguous southeastern counties of Bucks (375), Montgomery (492), and Delaware (411) have accounted for 47 percent.

Diagnosis

The diagnosis of Lyme Disease is problematic, since there are no highly accurate and commercially available laboratory tests. For surveillance purposes, the Pennsylvania Department of Health uses the case definition recommended by the Centers for Disease Control (CDC). It specifies either a physician diagnosis of the characteristic rash, erythema chronicum migrans (ECM), or a positive antibody test in association with one or more of the typical secondary or tertiary manifestations of the disease, including the cardiac or neurological manifestations or arthritis. However, this case definition should not serve as a hard-and-fast guide to physicians in their decisions regarding treatment. At times, because of the lack of reasonable alternative diagnoses, it may be appropriate to use a trial course of antibiotics effective against Borellia burgdorferi, the spirochetal bacteria which causes Lyme Disease, even in the absence of case definition criteria.

The problem is the various antibody tests used for Lyme Disease diagnosis are neither very sensitive nor specific, and they are characterized by a good deal of interlaboratory variability. They are therefore characterized by many false-positive and false-negative results, and they do not differentiate between acute versus remote, inactive infection.

Except for ECM, the most common manifestations of Lyme Disease—including arthritis, atrioventricular block, and neurologic manifestations (aseptic meningitis, cranial nerve palsies, and peripheral neuropathies)—are so commonly seen in other conditions that they are not much help alone in the diagnosis of Lyme Disease. ECM develops from two to 30 days following the bite of a tick infected with B. burgdorferi. It first appears as a red papule at the site of the bite, then gradually expands to leave a central faded area, giving it the typical ring-like appearance. There also may be secondary lesions. Unfortunately, diagnosis is made more difficult by the fact that ECM occurs in only two-thirds of cases.

Transmission

As stated before, B. burgdorferi is transmitted primarily by the bite of a tick. In Pennsylvania, the primary tick vector is Ixodes damini, the deer tick, although other tick vectors are of prime importance in other parts of the country and may also play some role in Pennsylvania. It is also suspected that some insects may play a role in transmission; some evidence exists that untreated pregnant women may transmit the disease to their fetus, thus resulting in fetal death. However, this appears to be quite uncommon. Theoretically it could be transmitted through blood transfusions, although to my knowledge this has never actually been documented.

Because ticks are the primary vector of transmission, public wooded areas are most commonly thought of as the places where people acquire disease. However, much residential property contains enough shrubbery or high grass to harbor the vector ticks, and disease acquisition on private residential property has been

Dr. Tavris is the state epidemiologist for the Pennsylvania Department of Health.

documented. Most notable in Pennsylvania in this regard is a recent cluster of several cases in a small neighborhood in Bucks County, where disease acquisition was found to be associated with gardening around the home. The fact that reported Lyme Disease in Pennsylvania is more common in women than in men also suggests that disease transmission around the home may be significantly more frequent than is commonly thought.

Control

The means of preventing and controlling Lyme Disease are quite limited. No vaccine exists, widespread efforts to apply pesticide to kill the vector tick would do tremendous damage to the environment, and targeted efforts at tick control are very expensive for the limited goals they achieve. At this time, the best means of control is to educate the public and the medical community.

The public should know that there is virtually no place in Pennsylvania which is known to be free of this disease. The following precautions may be taken with regard to exposure to wooded areas:

- Wear long sleeve shirts and long pants; tuck pants into socks.
- Walk in the middle of trails.
- Apply tick repellent prior to exposure.
- Carefully inspect clothes, self, children, or pets following exposure. Remove ticks with forceps by applying steady, gentle traction.
- Clear underbrush and trim vegetation around homes, where people are likely to be exposed.

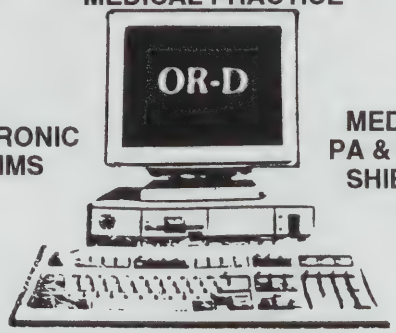
Physicians should be familiar enough with the disease to recognize the characteristic rash (ECM) and to consider it in patients who have the characteristic cardiac, neurologic, or arthritic manifestations when there are no apparent alternative explanations for them. The earlier in the disease process that antibiotic treatment is introduced, the more successful it is likely to be. Because no satisfactory diagnostic tools are available for Lyme Disease, in some cases therapy should be tried even without a clear-cut diagnosis.

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HCFA RESPONDS TO CLIA COMMENTS

Based on comments received on its proposed regulations on the Clinical Laboratory Improvement Act of 1988 (CLIA '88), the Health Care Financing Adminstration (HCFA) will make some "technical corrections" prior to the effective date of September 1, 1992. While more substantive changes may be considered later, several planned modifications will satisfy some concerns expressed by the State Society.

First, for example, the publication of the final regulation on procedures for a state to request exemption is expected "momentarily." If HCFA has reason to believe that a state will apply for exemption, it reportedly will not bill physicians this summer for the inspection fee, even if a final determination on the state's application has not been made. The physician, however, must still pay the initial registration fee and eventually the second fee to the state. In effect, it appears Pennsylvania will be granted the temporary exemption requested by the Society.

Second, in response to Society comments, HCFA will not impose a fee for inspections conducted in response to complaints found to be groundless; and the option of completing 20 hours of appropriate continuing medical education, or some equivalent mechanism, should remain viable for a physician to qualify as a first-time director of a moderately complex laboratory.

As for HCFA's initial survey of laboratories, it sent more than 600,000 HCFA-109 survey forms and received only 100,000 responses. Although the response appears consistent with the AMA's estimate based on its impact study, the administration believes many laboratories are not registering for various reasons. *Any State Society members who have not yet registered should do so as soon as possible, since effective September 1, 1992, Medicare will not reimburse for laboratory services if a laboratory is not registered.*

HCFA-109 survey forms can be ordered from the Society at 1-800-228-7823 or HCFA Region III at (215) 596-1351. Additionally, HCFA has initiated a hotline to answer questions related to CLIA '88. Survey forms can also be ordered through the hotline at (410) 290-5850. Note: physicians do not need to complete pages 5-6 of the survey form; HCFA will collect this data at a later date.

Physicians should also be aware that HCFA is now mailing the HCFA-35A CLIA Fee Remittance Coupon, the bill for initial registration of laboratories. The coupon will contain a laboratory's CLIA number, which must be recorded and used by laboratories in all future correspondence to HCFA.

On a final note, there is considerable concern at the state level that although the new system is supposed to be self-supporting through user fees, the federal government will not provide sufficient funds for states to accomplish inspection functions without additional resources.

News on CLIA

- Physicians should register labs STET—effective 9/1/92, Medicare will not reimburse lab services if a lab is not registered.
- HCFA has initiated a CLIA hotline—(410) 290-5850—to answer questions about implementation of the act.
- Labs should retain CLIA coupon, presently being mailed by HCFA. The coupon contains the lab's CLIA number, required for all future correspondence with the administration.

TASK FORCE SPONSORS FACT-FINDING CONFERENCE

The Joint Task Force on Child Abuse of the Pennsylvania Medical Society and the Pennsylvania Bar Association (PBA) sponsored a fact-finding conference on April 27 in Harrisburg to collect information about the child abuse reporting process and exchange ideas about systemic problems.

Approximately 30 experts in the field—including district attorneys, police officers, social workers, physicians, advocates for abused children, and an adult now dealing with abuse received as a child—testified before the task force. Roger F. Mecum, executive vice president of the State Society, said, "At the end of a long day of testimony, it was clear that many experts worried about the abused child who is scared and confused facing a daunting legal system." During the next several months, the task force will review the expert testimonies for common themes and problems. Then it intends to develop a series of recommendations for consideration by the boards of both the Society and the PBA. Many other problems were also identified.

Robert J. Lilley, assistant director of educational and scientific affairs, contributed to this page.

PMSLIC RELEASES HIV SURVEY RESULTS

The Pennsylvania Medical Society Liability Insurance Company (PMSLIC) has released the results of a survey conducted to determine physician opinion on the need for HIV insurance. The survey resulted from a 1991 House of Delegates action to investigate the need for HIV insurance in Pennsylvania.

Sixty-one percent of 7,000 PMSLIC policyholders completed and returned the survey of five HIV-related questions which, with aggregate results, follow:

1. How great a concern is HIV infection in your practice?
   11.6% High 27.6% Moderate 60.8% Low
2. Do you presently have income protection coverage if you become HIV positive?
   7.9% Yes 60.8% No 31.3% Uncertain
3. Do you believe that HIV income protection is an appropriate and desirable addition to your professional liability policy?
   53.5% Yes 19.4% No 27.1% Uncertain
4. Would you choose one professional liability insurance carrier over another if HIV income protection was included in that carrier's coverage?
   32.9% Yes 25.6% No 41.5% Uncertain
5. Should HIV income protection be offered as part of the standard paid coverage, or should physicians choosing that option be required to pay for it?
   46.6% For free 53.4% For a fee

In a letter to PMSLIC policyholders releasing results of the survey, Betty L. Cottle, MD, chairman of the PMSLIC board, wrote: "In considering all of the available information, the PMSLIC Board of Directors concluded we should continue to monitor the situation and watch carefully the coverage options that are available."

OBITUARIES

Nicolas A. Colosi, *Glenside*
Jefferson Medical College, 1938; age 80, died March 29, 1992. Dr. Colosi was a general practitioner.•

George W. Crouse, *Greensburg*
Case Western Reserve University School of Medicine, 1941; age 76, died April 13, 1992. Dr. Crouse was a general practitioner.•

Ervin Ellison, *Lancaster*
University of Cincinnati College of Medicine, 1943; age 73, died April 7, 1992. Dr. Ellison specialized in occupational medicine.•

Roscoe L. Fisher, *York*
University of Pennsylvania School of Medicine, 1936; age 80, died April 5, 1992. Dr. Fisher was an ophthalmologist.•

Robert L. Green, *Lafayette Hill*
Temple University School of Medicine, 1945; age 71, died April 13, 1992. Dr. Green was an orthopedic surgeon.•

Walter P. Havens Jr., *Haverford*
Harvard Medical School, 1936; age 80, died April 6, 1992. Dr. Havens was an internist.•

C. Merrill Leister, *Bethlehem*
Harvard Medical School, 1932; age 90, died March 5, 1992. Dr. Leister was a pediatrician.•

George P. Schmieler, *McMurray*
University of Maryland School of Medicine, 1936; age 82, died January 12, 1992. Dr. Schmieler was a general practitioner.•

D. Ernest Witt, *Bloomsburg*
University of Pennsylvania School of Medicine, 1944; age 72, died March 22, 1992. Dr. Witt was a family practitioner.•

Cyril R. Allen Jr., *Bridgeville*
University of Osteopathic Medicine and Health Sciences Des Moines, 1959; age 66, died March 31, 1992.

F. Benedict Lanahan, *Malvern*
Jefferson Medical College, 1935; age 82, died March 7, 1992. Dr. Lanahan specialized in occupational medicine.

Clennis R. Wheelock, *State College*
Temple University School of Medicine, 1954; age 70, died March 17, 1992. Dr. Wheelock was a general practitioner.

• Denotes membership in the Pennsylvania Medical Society at the time of death.

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Authors are asked to seek clarity, accuracy, and originality; attention to details of grammar, spelling, and typing are important. The title page should include the full name, degrees, and affiliations of all authors, and the name and address of the author to whom reprint requests should be sent. Tables must be typewritten and double-spaced on separate 8 1/2" by 11" sheets, with a title and number. Symbols for units should be confined to column headings; and abbreviations, properly explained, should be kept to a minimum.

Illustrations should be professional quality, black-and-white glossy prints. The name of the author, figure number, and the top of the figure should be noted on a label attached to the back of each illustration. Where photographs of patients are used, the subjects should not be identifiable or publication permission, signed by the subject or responsible person, must be included with the photograph. Material taken from other publications must give credit to the source; written permission for republication from the original publisher must be submitted.

References should not exceed 35 citations and should be noted consecutively in the text by superior numbers at the end of a sentence. The reference list should be typewritten and double-spaced on separate 8 1/2" by 11" sheets in the numerical order in which they are first cited in the text. The style of reference is that of *Index Medicus*:

1. **Goldwyn RM:** Subcutaneous mastectomy. *J Med Soc NJ* 74:1050-1052, 1977.
2. **Dixon WJ, Massey FJ:** *Introduction to Statistical Analysis*. New York, NY, McGraw-Hill, 1969, pp. 42-48.

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Directory Issue Coming Up!

The August issue of PENNSYLVANIA MEDICINE is the Society's annual membership directory. Not only a valuable resouce for physicians and other health care providers statewide, the Directory is also a unique opportunity for health care services to advertise to physicians. Contact the offices of this puyblication before June 26, 1992, to reserve advertising space for your organization.

How Does KePRO Compare?

Donald E. Harrop, MD

Last month, PENNSYLVANIA MEDICINE featured an overview of highlights of the Keystone Peer Review Organization's 1990-91 Annual Report. However, results published in the report are meaningless without meaningful comparison.

The 1990-91 Annual Report of the Keystone Peer Review Organization (KePRO) provided an in-depth look at statistics for various types of review conducted by KePRO under contract with the Health Care Financing Administration (HCFA). Although the report compared the year's review statistics with the those of the prior year, such numbers usually don't mean too much to anyone unless they are able to see how they stack up against someone else who performs a comparable service.

The tables below provide utilization and quality review statistics for each PRO in HCFA Region III, regional totals, and national totals. As the PRO for Pennsylvania, KePRO has a strong tendency to analyze these numbers only as PRO statistics without thinking of what they really represent.

For example, KePRO would interpret Table 1 to mean that 1.11 percent of all cases it reviewed during the first 27 months under the Third Scope of Work were denied. Likewise, in Table 2, KePRO would find 3,309 confirmed quality problems, or 0.91 percent. KePRO might then go directly to the other states, and to regional and national percentages, to see if it compares higher or lower,

However, let's look at the numbers in a different way. Of 366,029 cases reviewed, only 4,067 were denied. That means that in over a third of a million cases, Pennsylvania physicians and hospitals admitted patients appropriately 98.9 percent of the time. And in over a third of a million cases, 99.1 percent of patients received care which met acceptable standards as judged by physician peers of those who delivered the services.

While we at KePRO are pleased that statistically we compare favorably with other PROs, we need to recognize that the same statistics show the overall practice and delivery of medical care in the state to be above average. Pennsylvania physicians and hospitals have good reason to be proud of those numbers.

Comparative Statistics

Regional and National Data: Results of Third Scope of Work Retrospective Reviews, Completed Through February 29, 1992

Area	Inpatient Reviews	Utilization Denials	% of Cases Denied
Washington, DC	23,270	901	3.87
Delaware	22,583	363	1.61
Maryland	85,363	1,669	1.95
Pennsylvania	**366,029**	**4,067**	**1.11**
Virginia	154,707	1,475	0.95
West Virginia	60,345	902	1.49
REGIONAL	712,297	9,377	1.32
NATIONAL	6,002,776	102,298	1.70

Data provided by the Central Office of the Health Care Financing Administration

Dr. Harrop is president of the Keystone Peer Review Organization.

Comparative Statistics

Regional and National Data: Results of Third Scope of Work Retrospective Reviews, Completed Through February 29, 1992

Area	Inpatient Cases Screened	Confirmed Quality Problems *	% of Cases with Problems
Washington, DC	22,031	191	0.87
Delaware	22,563	190	0.84
Maryland	84,641	1,242	1.47
Pennsylvania	**364,786**	**3,309**	**0.91**
Virginia	153,705	860	0.56
West Virginia	60,284	1,029	1.71
REGIONAL	708,010	6,821	0.96
NATIONAL	5,955,086	85,278	1.43

Data provided by the Central Office of the Health Care Financing Administration

*Relating to HCFA-mandated inpatient generic quality screens



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AIR FORCE

ACTIONS OF THE BOARD OF TRUSTEES, APRIL 14, 1992

BOARD REAFFIRMS SUPPORT OF DATA AVAILABILITY

At the recommendation of the Society's Task Force on Health Care Cost Containment, the Board reaffirmed its support of the public availability of valid and reliable information related to the cost and quality of health care services in Pennsylvania.

In response, the Society will actively pursue—through legislative amendments and budgetary processes—implementation of several principles relating to the structure and operation of the Pennsylvania Health Care Cost Containment Council (PHC4), the independent state agency which compiles such information. For example, the Society will seek:

- an in-depth, independent audit of the cost effectiveness of the health care cost containment effort;
- assurance that PHC4 accurately and effectively collects, validates, and publishes appropriate mandated health care data through sufficient funding;
- increasing physician representation on the council from one member to four;
- the establishment and utilization of a technical advisory group to assist the council in carrying out its responsibilities; and
- the establishment of a committee to continuously study quality of health care systems and report regularly to the council.

The Society also called for PHC4 to require purchasers to help defray costs of special reports; require itemized hospital bills only on patient requests; and actively involve the State Society and specialty societies in the planning, validation, and review of physician-specific data reports.

POLICY FORMATION EFFORTS TO CONTINUE

The Board authorized the Committee on Long Range Assessment to continue development of the State Society's policy on state and federal health care reform movements.

The committee has held three meetings since accepting the assignment earlier this year to develop for the Board's consideration the Society's response on the reform issue. Primary discussion at these meetings has focused on formulating a set of health care reform policy goals to use in developing the Society's position.

The Committee has developed a proposal, not yet board approved, which "is intended to represent the Society's commitment to reform and to foster an overwhelming consensus of agreement and support from both our members and our patients." The goals addressed in the proposal relate to access, quality of care, cost containment, practice parameters, health insurance reform, public health initiatives, tort reform, basic freedoms, prioritization, and medical research and education.

Once such a document is designated as policy by the Society, it would be used to respond to the media, develop the Society's own health care reform proposal, and evaluate the merits of plans advocated by other organizations and legislators.

TRUSTEES APPROVE IMG RECOMMENDATIONS

Several recommendations of the Committee on International Medical Graduates (IMGs) were approved by Society trustees at their April meeting, and since then several related actions have occurred.

One approved recommendation directed the State Society to urge the State Board of Medicine to study the feasibility of using the AMA National Credentials Verification Service (AMA/NCVS) as part of the licensing credentials verification process. Consequently, at its April 28 meeting, the State Board voted unanimously to investigate the possibility of using the AMA/NCVS to assist in the licensing process.

Through approval of a second recommendation, the Society encouraged the State Board of Medicine to establish "grandfather" provisions for physicians who have taken previous versions of qualifying examinations prior to implementation of the new United States Medical Licensing Exam. The Board also authorized appropriate Society representatives to provide input into State Board deliberations on the subject. Since that time, the Society's Committee on Medical Education has reviewed regulations drafted by the State Board, and the committee believes they adequately address the concerns of the Committee on IMGs.

Finally, by approving a third recommendation, the Board authorized representation of the Committee on IMGs in the Society's review of the 1985 Medical Practice Act, which is scheduled to sunset in 1995.

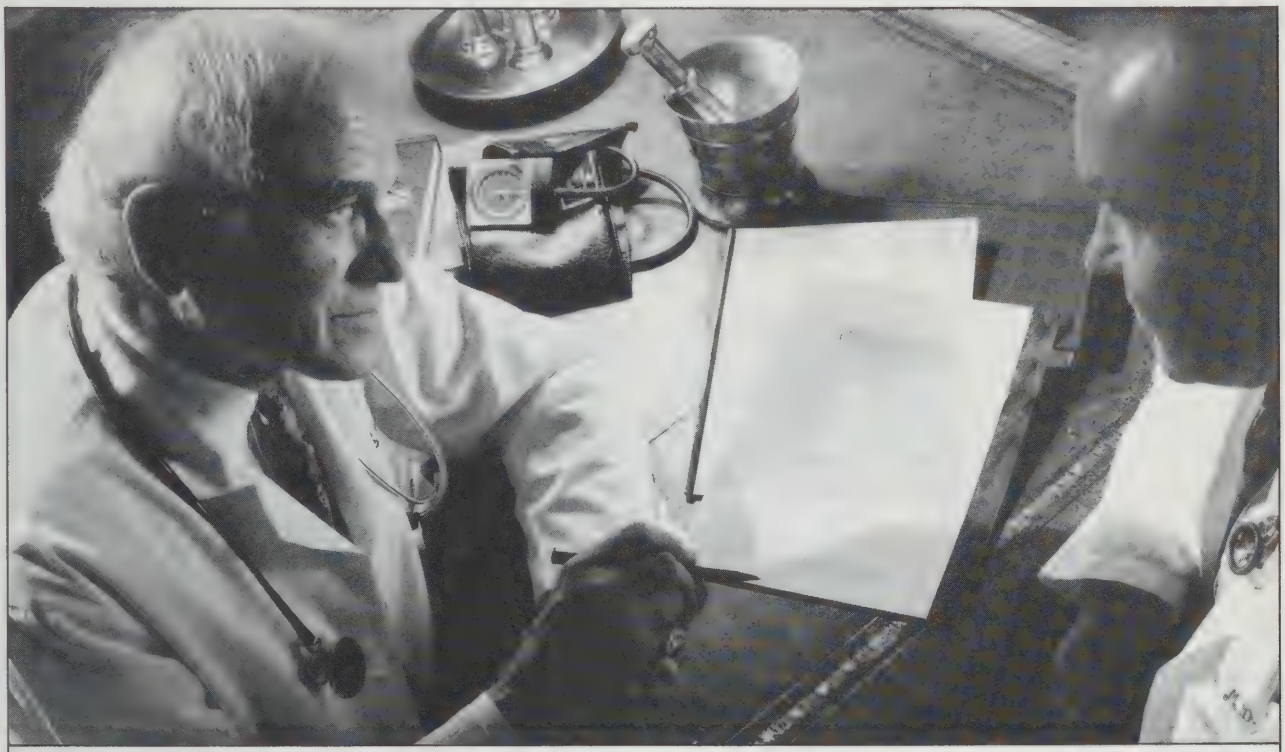
DR. GRECO TO CHAIR CONFERENCE COMMITTEE

Victor F. Greco, MD, Twelfth District trustee, was elected chairman of the Society's 1993 Leadership Conference Committee, succeeding Frederick G. Brown, MD, Danville. Dr. Greco is a thoracic surgeon in Drums.

Other Board members elected to the committee include: Edward H. Dench Jr., MD, Sixth District; Donald G. Ferguson, MD, president elect; John W. Lehman, MD, Tenth District; John W. Mills, MD, Ninth District; James R. Regan, MD, Interspecialty Section; and Howard A. Richter, MD, vice speaker of the House of Delegates.



The Society's Board deliberates as John A. Malcolm, Jr., MD, makes a presentation as chairman of the Task Force on Health Care Cost Containment.



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Dealing with Stress in the Physician's Marriage

Penelope P. Ziegler, MD

Practicing medicine in the 1990s brings a high-stress lifestyle, and no one knows that better than the spouse of a physician. While television and cinema have portrayed the medical family as an all-American ideal, the reality can be very different.

"The physician's identity is so closely bound to the world of medicine that, despite the best of intentions, practice demands inevitably take priority over the demands of the relationship."

Dr. Ziegler is medical director of the Physicians' Health Programs of the State Society's Educational and Scientific Trust.

Surveys show that while the rate of divorce in physicians' marriages is less than the national average, the degree of conflict, instability, and dissatisfaction is significantly higher. Certain medical specialties have markedly higher divorce rates than others, with orthopedic surgery and psychiatry leading the list. Also, female physicians are much more likely to divorce than are their male colleagues.[1]

The medical marriage: pros and cons

To understand the origins of problems in the medical marriage, first consider how these relationships become established. Choosing to marry a physician has certain obvious advantages. Even if the bond is formed during the relatively lean educational years, a physician's partner can look forward to a high likelihood of material success and social status tempered with altruism and humanistic values.

The physician and his/her prospective spouse, like other couples, are drawn together by shared interests, values, and goals, as well as sexual attraction and mutual affection. If they are contemplating children, they recognize their ability to provide comfortably for the needs of a growing family.

But there are many accompanying disadvantages to choosing a physician for a spouse. The physician's identity is so closely bound to the world of medicine that, despite the best of intentions, practice demands inevitably take priority over the demands of the relationship. Long periods of time apart—forced by emergencies, on-call schedules, and the "tyranny of the telephone"—rob the couple of the closeness and privacy needed to nurture intimacy and trust. Deferred gratification becomes a way of life, and each new, eagerly awaited milestone ("when I finish school, internship, residency, the boards, etc.") fails to fulfill its promise. "Just wait until ..." becomes a familiar theme song of countless arguments over disrupted evenings and holiday disappointments.

The two-career couple

These days, many physicians' spouses are professionals who derive much of their gratification and sense of self from their own careers. A special subset of this two-career group is the so-called "dual-doctor marriage." It is estimated that 40,000 or more physicians in the United States are married to other physicians, and this number has been increasing rapidly over the past 10 to 15 years as the number of female physicians and medical students increases.[2] Physician-partners report many advantages of such unions, including the ability to empathize and share the pain associated with training and practice, and an increased understanding and acceptance of such insanities as on-call schedules, sleep deprivation, and constant interruptions of leisure time.

Two-career marriages also present special challenges to these couples, whether both are in medicine or one spouse's career is in another field. Questions about priorities and whose career determines major life choices abound. Who makes career sacrifices for the sake of the other's career? How are family roles assigned? How are mundane chores and duties divided? How can the couple ensure adequate parenting for their children and still find time for the care and feeding of their own relationship? These are tough questions with no easy answers. Not surprisingly, surveys show that in many of these families, the female professional assumes most, if not all, of the responsibility for household management and child care, in addition to her career demands.[3]

The "traditional" medical marriage, still the most common pattern today, is that in which the husband is the physician and the wife is devoted to caring for the home and family. While she may be em-

ployed or very active in community service, it is mutually understood that his career is the focal point of both of their lives. The challenges and stresses which arise in this setting have been explored through surveys, in-depth interviews with couples seeking marital counseling or participating in growth-enhancing seminars, and case reports of individuals seeking psychiatric treatment for symptoms related to marital stress.[4,5]

Areas of conflict

A relationship is in distress when the partners' expectations and needs are at odds with the existing reality in any of the important areas that make up a stable, satisfying union. In most surveys of physicians and spouses, the area of conflict most often cited is time together. Time is the rarest commodity for most physicians to bring to their marriages.

There is also the issue of how to spend available time. When the time factor is explored in-depth, spouses feel a strong need for time to talk with each other, while physicians are more likely to use their leisure periods working on home-improvement projects, participating in sports activities, or catching up on professional reading.

This observation suggests that, in addition to the quantitative lack of time presented by the demands of medical practice, problems stem from discrepancies in communication style, perceived needs, and relational priorities. To understand the origins of this deeper level of distress, the focus needs to be on physicians' personality traits and strategies for coping with conflict.

Personality traits

To succeed in the highly competitive arena of pre-medical and medical education, the physician-to-be must have certain skills and abilities which will allow him or her to survive and flourish in a toxic environment. Intelligence is not enough; one must also be compulsive, relentlessly driving toward a desired goal while ignoring distractions not relevant to achieving that goal. It helps to be a perfectionist, intolerant of failure or inadequacy in oneself or others. Other useful traits include emotional detachment, tremendous tolerance for deprivation and humiliation, the ability to defer gratification indefinitely, and the capacity to think fast under pressure while physically exhausted and sleep-deprived.

How do physicians acquire this set of survival skills? The best "school" for teaching these traits to children is a dysfunctional family system. Therefore, it is not surprising to discover that many physicians and medical students grew up in families troubled by alcoholism, physical or psychiatric illness in a parent, or some other identifiable problem.

The doctor-to-be, as a child, functioned as the "family hero." He or she brought positive energy to the family unit through achievement and recognition of excellence. Perhaps this child took on a super-responsible role in the face of parental inability and was rewarded for this behavior. Overachieving and caretaking brought satisfaction and gratification, so the young person was drawn strongly toward a "helping" profession. Even many physicians who find no evidence of overt dysfunction in their families identify with this "hero" role. As adolescents and young adults, they report a relentless need to accomplish more, to achieve greater success, and to receive recognition in order to win parental approval.[6]

The physician's spouse-to-be may bring similar issues to the union. Although no large-scale surveys have addressed this issue, interviews with spouses in marital therapy and spouses of physicians who are in treatment for alcoholism or drug addiction suggest that a higher-than-expected percentage of physicians' partners may also be products of dysfunctional families. Common traits found in these groups include: distorted self-concept with low self-esteem, difficulty expressing feelings verbally, fear of loneliness, and loss of self.

Family rules

Both partners may bring to the marriage a collection of self-defeating personality

"In most surveys of physicians and spouses, the area of conflict most often cited is time together."

traits, as well as a lack of experience in how to build a healthy, balanced family life. Without a conscious awareness of the risks and a concerted effort to avoid the pitfalls, such a couple is likely to develop family "rules" which lead to continuing, unresolved stress for all family members.

For example, one of the most common unwritten rules is, "Don't talk about problems." Under this rule, it is not okay to express negative feelings openly because it might cause an uproar and make the situation worse. Family members must act like everything is fine and not rock the boat in the hope that "it" will blow over. Over time, the family playing by this and other stress-enhancing rules will develop a deep-seated, festering abscess of anger, hurt, and fear which poisons intimacy and trust in the relationship.[7]

Such a couple may drift farther and farther apart, and one or both partners may look outside the marriage to find what is missing. Extramarital affairs are an obvious symptom of serious trouble. Other, sometimes less obvious, signs include:

- symptoms of depression and/or anxiety;
- sleep disturbances;
- physical problems, including headaches, G.I. upset, back pain, etc.;
- increased alcohol or drug use;
- frequent arguments or increased intensity of fighting, i.e., getting more physical with pushing, shoving, or name calling;
- avoiding each other; and
- a loss of interest in sex and/or physical displays of affection.

All of these may be indicators of a need for professional help in identifying the sources of conflict, setting new goals and directions, and changing the "rules" to allow the relationship to grow.

Sexuality and intimacy

In any discussion of medical marriages, intimacy and sexuality deserve special mention because complaints in these areas are universal among medical couples in marital therapy. Despite their professional education and exposure to the physiology of human sexuality, many physicians are not comfortable discussing sexual matters with their spouses. In fact, a number of physicians who describe themselves as entirely comfortable with patients' sexual complaints and who routinely advise patients about the importance of open, frank discussions between spouses about sexual matters, have admitted they do not follow their own advice in the marriage bed, with predictable problems resulting.[8]

Many studies of medical families do not address the issues and needs of gay and lesbian physicians and their relationships. In his book, *Doctors' Marriages*, Michael F. Myers, MD, explores gay and lesbian families and their similarities and differences as compared to heterosexual couples. Some of the special stressors with which these families struggle include social prejudice and stigma; isolation from medical peers and, for some, from the family of origin; "coming out" conflicts and internalized homophobia; and, for gay men, HIV/AIDS.[9]

Parenting issues

In some medical marriages, the overt conflict revolves around issues of parenting. In the early years, questions about whether and when to have children begin to arrive. Disputes later arise over role definitions, division of responsibilities, discipline, day care, schooling, and religion. These are the usual dilemmas with which all families contend. However, if some physicians' families experience more than their share of strife over childraising, it may be related to their lack of healthy role models and to the persistence of those unwritten rules which block meaningful communication and problem-solving.

A myth tells us that doctor-dads are absentee fathers because of the time pressures of practice. Some fathers admit that an additional factor is lack of confidence in the parental role; and worse yet, some see themselves recreating their own fathers' role of family terrorist. Some doctor-moms experience similar uncertainties and insecurities. Such problems can and should be addressed through family therapy aimed at opening channels of communication, as well as teaching good parenting skills.

The importance of communication

As medical practice and the physician's role in society continue to change, the external stressors brought to bear on the medical family will also increase. Individual physicians and their spouses will have

little control over megatrends in medical economics, health care delivery, and education, let alone over the public's attitude toward and the image of the physician and his/her family. What physicians and their partners can change is the way they approach their relationships and the strategies they employ in dealing with the inevitable stresses and problems to which they are vulnerable.

For example, the "rule" about dealing with problems can be changed to, "Do talk openly about problems, and give each other permission to express feelings." Operating under the new "rule" will be anxiety-producing at first, especially when angry feelings are involved. This is because neither partner is used to hearing anger expressed directly, and because people learning to express feelings openly tend to be overly aggressive until they "get the hang of it." However, with practice, the couple will become increasingly comfortable with their new style of relating. Increased sensitivity to each other's needs will develop.

This new approach starts with acknowledging the central importance of open, honest communication within the marital partnership. This, coupled with a willingness to seek help when communication begins to break down rather than waiting until it has ceased completely, can help physicians' families cope effectively with stress, to ensure that the medical marriage survives.

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Motivating Employees to Be Team Players

The Health Care Grap

How important is communication among employees in a medical office? Simply put, it can make or break the effectiveness of a medical practice.

Communication is the most fundamental building block in motivating office staff to work as a synchronized team. But all too often, the hustle of the daily routine leaves little time for physicians and staff to sit down and discuss problems, share ideas, or exchange vital office information.

At the most basic level, creating an atmosphere of teamwork among members of an office staff, and between doctors and staff, means making conscious efforts to keep employees abreast of all newsworthy events in a medical office. Relating to staff as team players means keeping them updated on new developments in the office, such as the introduction of new medical equipment, the use of new drugs in the practice, or the arrival of new employees. Even issues as simple as changes in hours, fees, and codes need to be communicated effectively.

By communicating changes or developments such as these directly to staff members, a physician is sending a clear message that staff members are an integral part of the team. Employees also need to be encouraged to voice their feelings and ideas for improvement. In this way, physicians also let them know their contributions as professionals and individuals are valued.

As a consulting firm, The Health Care Group has encountered practices where a physician took on a new associate, but never bothered to inform the staff of the new doctor's background and the additional services he offered. This type of management oversight fuels the flames of employee discontent and results in a wide range of negative repercussions in the office, from increased employee grumbling and lowered morale, to waning productivity. In the long run, the most damaging "trickle-down" effects of unhappy staffers will reach patients and colleagues.

Consider the example of another client, an established pediatric practice, which recently hired a new nurse practitioner, yet never formally described her training and capabilities to the office staff. Without knowledge to the contrary, everyone in the office simply assumed that the new assistant was a nurse, and therefore failed to take advantage of the full range of skills she offered. In this case, not only did the employees feel left out of an important exchange of information, but the practice suffered a financial loss as a result of poor personnel management.

How can physicians ensure that important developments are communicated accurately? One way is to establish internal staff meetings. Meetings can provide an important forum not only for vital exchange of information, but also for all employees to meet and commonly evaluate or work together to substantially improve office morale.

• *Schedule regular meeting times*: Very different from crises meetings, staff meetings should be scheduled at regular intervals to create a habit of constructive participation. Once a month is a good rule of thumb. Even practices with satellite offices should conduct a monthly meeting at each facility. All employees should be encouraged to attend, including part-time employees, so they understand it is part of the work experience.

• *Set an agenda*: To be effective, staff meetings should be scheduled with prearranged agendas, so staffers understand the meetings are not meant to be general gripe sessions. At least one doctor should attend meetings periodically but should avoid taking undue control. The office manager—not a physician—is best suited to run the meetings, and some meetings are best left to just the manager and the staff.

• *Distribute minutes of each meeting*: The office manager should take minutes of the meeting and type and distribute them to all attendees. Minutes formalize the meeting's importance, keep employees aware of issues affecting the practice, and help prepare everyone for the next meeting. Any questions should be followed up by the manager, who should report on these items at the start of succeeding meetings. Employees will respect staff meetings much more, and contribute to them more, if they know management cares enough to act on ideas that arise. In addition, staff meetings enhance office productivity: when staff members know that a specific issue can be discussed in a regular forum, they will not use time and energy raising the matter through other channels.

• *Use meetings as educational forums*: Managers can also spice up staff meetings with clinical educational briefings. Ten minutes of each meeting can be devoted to physicians' describing one clinical aspect of the practice in terms appropriate for the employees' experience and training. These discussions not only keep meetings interesting, but convey to employees the desire to share experiences with them. They also help create a more responsive and enthusiastic staff.

Although staff meetings may seem to click initially, developing effective meetings usually takes a little time and patience. The practice will benefit from employees who know that their contributions as members of the team are highly valued.

Using staff evaluations to motivate

Another way to boost staff morale is through regular job performance evaluations. Surveys of medical offices have shown that lack of appreciation for good work and conscientious efforts is a prime cause of poor employee morale. Although some physicians fear that praising employees' work will create pressure for a large pay increase, this fear is unfounded in a healthy office environment.

The rule of thumb is to evaluate employees at three months, six months, and one year. Long-term

staffers should be evaluated at least once a year, with some practices preferring evaluations every six months and salary reviews annually. During these individual meetings with the employee, the physician or office manager can build rapport by soliciting and listening to the staffer's concerns.

Too often, salary reviews are seen only as opportunities to criticize employees. Motivation, however, works in both directions, and equally important is acknowledging outstanding performance and conveying support and satisfaction to employees.

Motivating through training

Staff training can be an additional route to motivating employees. Not only do training programs ensure that employees have the specific skills necessary to do the job correctly, but training helps all staffers understand how their jobs relate to those of others and to the overall function of the practice. Also, most importantly, training encourages each employee to contribute maximum effort and thought, and to fully develop his or her potential in medical practice management. Training session topics might include: effective handling of telephone calls, refining the office scheduling procedures, developing a consumer-oriented mentality, and enhancing the staff's patient education abilities.

Giving staff some medical education is one training effort that can pay off handsomely. Whether during staff meetings or daily routines, spending some time describing the practice's clinical aspects will help employees appreciate and understand their jobs better.

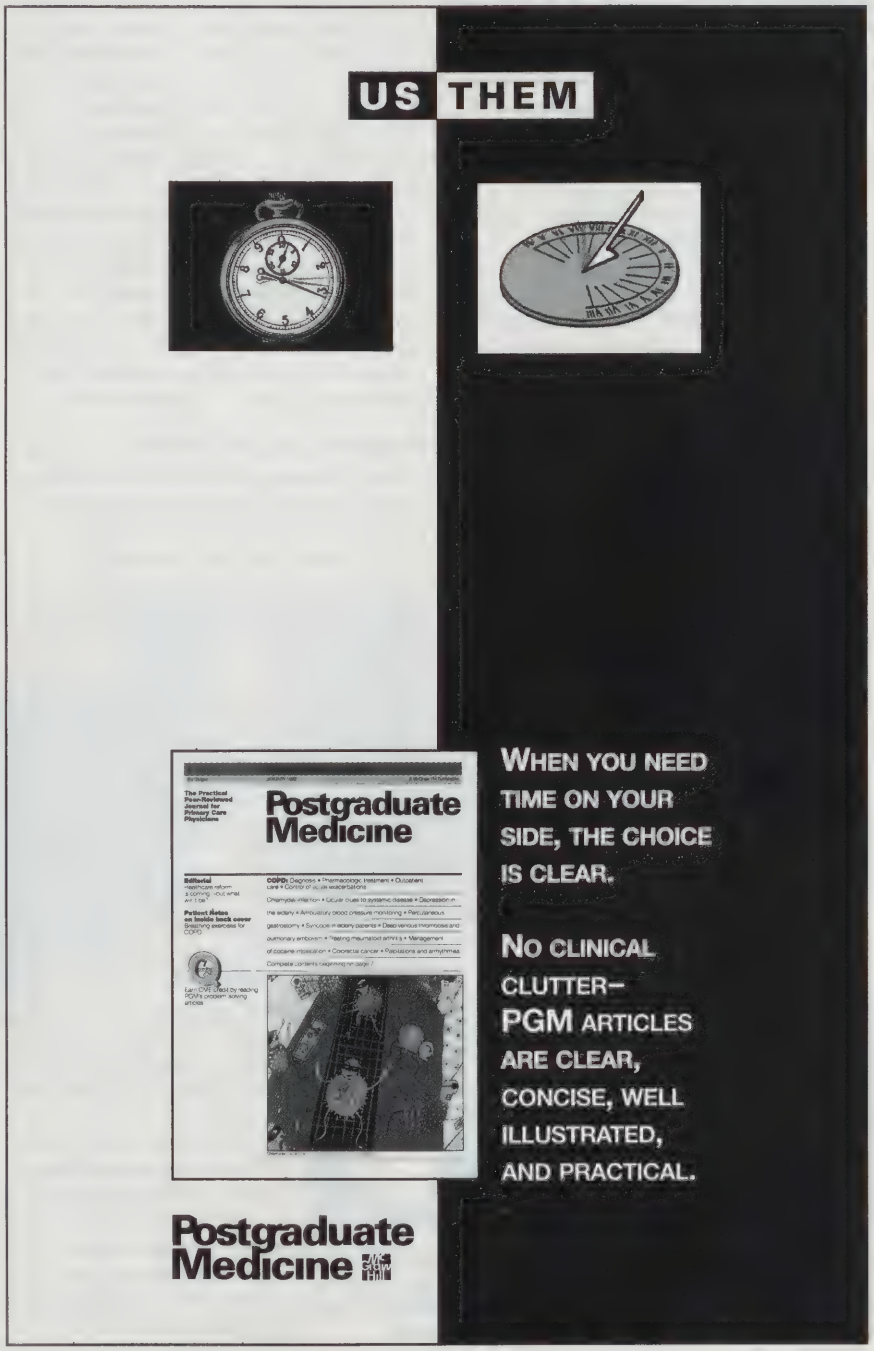
Taking a "preventative approach" to employee motivation is more than good personnel management; it can also be a very worthwhile business investment. A motivated, trained staff can be a physician's most powerful marketing tool and can contribute far beyond their specific skills to the practice.

The contributing authors, Dorothy R. Sweeney and Edward L. Grab, are consultants with The Health Care Group, a medical practice management consulting firm based in Plymouth Meeting.

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Practice Management Questions?

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Leaders Gather to Discuss "Survival"

More than 260 Pennsylvania physicians gathered in Hershey, April 14-15, for the Society's 1992 Leadership Conference, "Survival on the Highwire." During the course of the two days, attendees discussed their own survival in the changing medical arena and had the opportunity to learn more about practice parameters, liability reform, managed care, political involvement, and improving leadership skills.

Keynote address

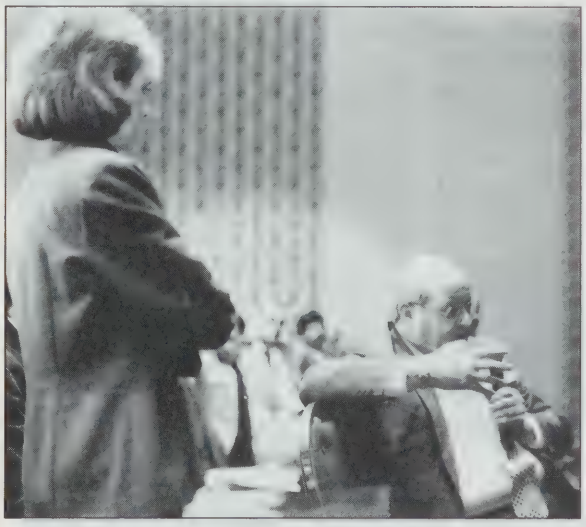
Robert E. McAfee, MD, vice chairman of the AMA Board of Trustees, presented the keynote address on practice parameters, following an animated videotape welcome developed and produced by the Society, and a greeting by Fred Brown, MD, chairman of the Leadership Conference Committee. Dr. McAfee said that while he hears many negative comments about practice parameters, they may be the "salvation" of the profession. "They are guidelines, standards, and they are not new to the profession," he said. "They are parameters of acceptable care—they don't dictate, they give options."

Prior to developing practice parameters, a lengthy research process compiles specific outcome data and reviews and tests it. Dr. McAfee explained that such data can be useful to physicians: after evaluating the data and its nature, physicians may then use it to decide whether or not they need to change their practices to offer higher quality of care. In response to concerns of evaluating physicians on the basis of outcome-specific data, Dr. McAfee, a member of the AMA's Practice Parameters Partnership, asked, "What else would you want to be measured on?"

He ended his presentation with his "observations" on health care reform in the U.S., touching upon such factors as the growth of the aging population, the nation's demand for quality, the intensity of care required, the problems of utilization, and the role of managed care in America.

Reforming medical liability

In regard to medical liability reform, physicians and administrators are focusing on the wrong problem, according to Lucian Leape, MD, lecturer at the Harvard University School of Public Health and Tufts University School of Medicine. "Liability is the symptom," he says. "The real disease is medical injury."



Robert E. McAfee, MD, (right) vice chairman of the AMA Board of Trustees, challenges panel members during a discussion moderated by Alice G. Gosfield, Esq., (left) Philadelphia health care law specialist, at the 1992 Leadership Conference.

Dr. Leape led a plenary session on the issue as part of Tuesday's schedule. During the session, he presented data compiled to study to what extent negligence and death are related to medical injury. His findings showed that in 1984 in New York, approximately 27,000 of 98,600 injuries (27 percent) were due to negligence, 15,000 deaths occurred due to the injuries (15 percent), and of that an estimated 50 percent of the deaths resulted from negligence. When he transferred those numbers to a national level, he found that more that 200,000 deaths occurred each year in the U.S. due to negligence.

He stressed, however, that not all medical injury is caused by physicians. Any reform plan would need "to give hospitals incentives to make their environments safer," he said, and the right plan could help "put physicians on the side of patients, where they belong." The key to reforming the system, according to Dr. Leape, "is to stop thinking of malpractice as crime and punishment, and start thinking of it as prevention and compensation."

He suggested that 70 percent of adverse effects are preventable and concluded with the following five suggestions to enhance existing efforts in reducing negligence: 1) expand methods to identify and track errors; 2) rethink the way mistakes are dealt with, e.g., not *who* made the mistake, but *why*; 3) prevent falls; 4) introduce technology to institute computerized medication ordering; and 5) rethink the technical education process.



According to Lucian Leape, MD, nationally known lecturer and a speaker at the 1992 Leadership Conference, "Liability is the symptom. The real disease is medical injury."

Questioning managed care

Alice G. Gosfield, Esq., health care law specialist from Philadelphia, returned to this year's Leadership Conference by popular demand. She had moderated a 1990 Leadership Conference forum on "Governmental Transitions in Medical Care."

The Society invited Gosfield back this year to moderate, "Can Quality Medicine Survive in a Managed Care Environment?" Joining her as panel members were Neil Schlackman, MD, medical director of U.S. Healthcare, Blue Bell; Michael A. Hattwick, MD, practicing physician, Annandale,

Virginia; and David B. Nash, MD, director of health policy and clinical outcomes at Thomas Jefferson University and Jefferson Medical College, Philadelphia.

Each panel member reacted to the question posed in the session's title. Dr. Nash said that the question itself is "an interesting reflection of the membership, [and confusion occurs because] the marketplace is infiltrated by different models under the umbrella of managed care." He believes managed care is a viable option for hospitals.

Dr. Schlackman called "managed care" a "misnomer." He said physicians have always "managed care," and what they were really talking about was "OWAs—other weird arrangements." Such arrangements can work and physicians can use guidelines to improve care, he said, "but physicians and others need to make the guidelines...everyone needs to participate." Dr. Hattwick said that, to achieve quality medicine, the nation needs "a health care system with the single goal of assuring basic quality of care for all and promoting excellent quality care for each."

Gosfield and audience members then posed questions and scenarios to the panel members. Access/quality of care issues and physician participation in managed care were among "hot topics" of interest. Following the discussion, the audience was encouraged to participate in breakout sessions with panel members.



David B. Nash, MD, (left) director of health policy and clinical outcomes at Thomas Jefferson University and Jefferson Medical College, listens as Neil Schlackman, MD, (right) medical director of U.S. Healthcare in Blue Bell, reacts to the question, "Can Quality Medicine Survive in a Managed Care Environment?," at the Society's 1992 Leadership Conference in April.

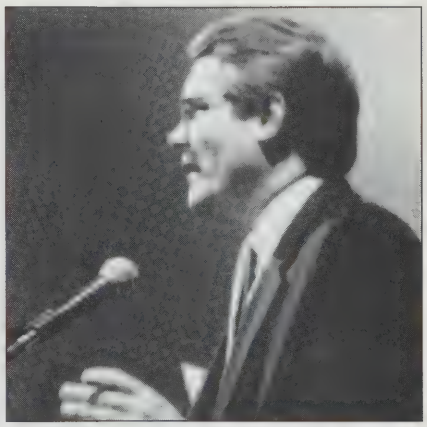
Debating election '92

Two national political commentators opened Wednesday's meeting schedule with a debate about the 1992 presidential election and where health care fits into campaigning. Eleanor Clift, *Newsweek* correspondent, and Fred Barnes, *The New Republic* writer, presented the hour-long, point-couterpoint session to a full house.

According to Barnes, "There is not a health care crisis in this country. We have quality health care, and the uninsured do get health care, just less of it." So why is health care not the big issue of the election? He cited two main reasons: 1) Senator Harris Wofford's recent campaign really was *not* about health care, but more about recession; and 2) focus groups show Americans really *do not know* what they want in a health care system, except that they *don't* want national health care or health insurance, and they *don't* want government involvement."

Clift countered, saying that health care is "the only uncontrollable portion of the budget" and *will be* important to the election. She noted that candidates and analysts should not underestimate "senior citizens as a voting power"; and she believes that the U.S. will have a some type of health care system in place within four to five years: "Not either/or—not the present system or the Canadian system." Instead, she said, it will incorporate elements of a number of existing systems.

Barnes predicted that George Bush will win this year's presidential election, citing several reasons Bill Clinton cannot win, including the issue of his character and his inexperience with foreign policy. In response, Clift said, "Bill Clinton is still standing. He has thought about where to take the country domestically, and debates will be important [to his campaign, because] at that time, Clinton will show the public he has ideas on foreign policy, economics, and health care."



Fred Barnes, writer for *The New Republic*, defends his views on the 1992 presidential election during a point-counterpoint session at the 1992 Leadership Conference.

Clift and Barnes agreed that H. Ross Perot is a "wildcard" in the election. Barnes said "Bush and Clinton should both be worried about particular states—Texas, California...he will take votes from Clinton." According to Clift, "Perot will be important in the spring, but not later on." They concluded their debate by touching upon potential running mates and several other potential campaign issues.

Other highlights

On Tuesday afternoon, county leaders were invited to a policy session held "to open the avenues of communication between the different tiers of organized medicine." Attendees were given the opportunity to question state and national leaders about societal concerns.

For instance, Robert E. McAfee, MD, vice chairman of the AMA Board of Trustees, talked about the value of the AMA in response to negative comments about unification. He suggested that physicians not look at the AMA as an "umbrella" organization, since that can be considered "confining" and be associated with "inclement weather." Instead, he said, the AMA's long-standing role in the U.S. in setting guidelines in medical science, ethics, and medical education should stand to prove it the highest level of

organized medicine.

The session, which ran a half-hour beyond the originally scheduled hour, turned out "quite well" according to attending leaders. Several suggestions were made by county leaders for consideration at state and national levels.

Among other highlights of the 1992 Leadership Conference were a Tuesday evening dinner, sponsored by the Pennsylvania Medical Political Action Committee, featuring Rob Rogers, editorial cartoonist for *The Pittsburgh Press*; and a Wednesday morning breakfast, sponsored by the Pennsylvania Medical Society Liability Insurance Company, featuring R. Faser Triplett, chairman of the American Medical Political Action Committee.

Following workshop sessions on diversity, practical political involvement, physician and hospital relationships, and leadership skills, the two-day conference ended Wednesday at noon with an address by Society President Robert N. Moyers, MD. He reiterated the importance of political involvement by physicians, presented several ways to succeed with that involvement, and concluded with a thank you to attendees for their interest and cooperation.

WORKSHOPS ADDRESS DIVERSITY, POLITICS, SKILLS

After a full day of debate and discussion on broad health care issues, attendees at the Society's 1992 Leadership Conference were offered workshops developed to address specific issues and skills. Topics of the concurrent sessions included



Diego J. Gonzales, MD, (left) and Lynn Michele Lucas-Fehm, MD, (right) discuss their views and experiences during the "Diversity" workshop, sponsored by the Institute for Physician Leadership of the Society's Educational and Scientific Trust.



Dr. George Trajtenberg of Chester County Hospital in West Chester offers his views during the audience participation portion of the "Diversity" workshop.

ethnic diversity in the physician community, political involvement, peer review, stress management, presentation skills and image building, and physician and hospital relationships.

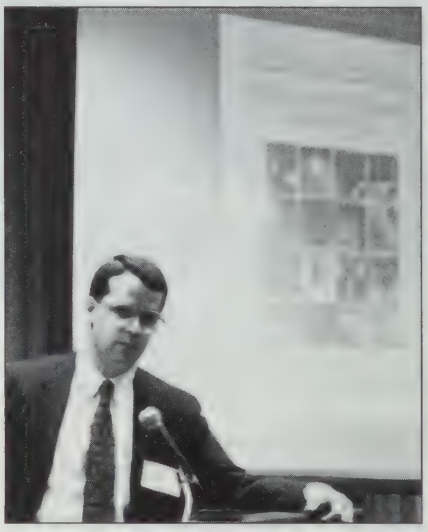
Highlighting the sessions was a discussion entitled, "Diversity: A Workshop for the Future Leaders of Medicine." Sponsored by the Institute for Physician Leadership of the Society's Educational and Scientific Trust, this workshop gathered panelists "to explore the future leadership of organized medicine in Pennsylvania and the effect an increasingly diverse population will have on it."

Panelists included: Betty L. Cottle, MD; Lynn Michele Lucas-Fehm, MD; Diego J. Gonzales, MD; and Jitendra Desai, MD. Each talked about their personal experiences as a physician of diverse background. Audience members were then given the opportunity to question the panelists, who voiced their ideas for handling specific situations and being more accepting and understanding of physicians of diverse backgrounds. The session was well-received and offered many interesting and eye-opening views to attendees.

State Representatives John H. Broujos and Samuel E. Hayes Jr. joined Melissa B. Ross, a representative of the American Medical Political Action Committee, in leading the workshop, "Practical Political Involvement for Physicians." During the presentation, Representative Broujos said, "Political activity is part of the process, [and] doctors talking to politicians is important." Representative Hayes added, "If you don't do your business on Capitol Hill...someone else will do it for you." Practical tips were also offered for physicians to become more effective with their grassroots political activities.

Michael Sheehan, a communications consultant from Washington, DC, led "Presentation Skills and Image Building," a workshop designed to improve leaders' skills when communicating with the public, legislators, and peers. Sheehan offered the "three Ms"—message, messenger, and medium—and used videotaped segments of nationally known figures to demonstrate good and bad speaking techniques and their effectiveness. The response to the workshop was overwhelmingly positive.

Two seminars were offered to help physicians deal more effectively with the pressures and evolving forms of the medical field. In the first, a stress management workshop subtitled, "Is Stress Worth Dying For?," physicians were given statistics on stress levels of their specialties. Led by nationally known speaker, Robert S. Eliot, MD, FACC, this workshop analyzed the causes and effects of stress, and



Richard J. Lipovich, senior manager for Arthur Andersen Healthcare Services in Pittsburgh, answers questions during a workshop about "The Future of Health Care," a study of the health care environment of the future.

offered mechanisms for physicians to use in reducing stress. The second workshop addressed one common stressor for physicians: peer review. Donald E. Harrop, MD, president of



State Representative Samuel E. Hayes Jr. relays practical tips for increased physician involvement on Capitol Hill during a political involvement workshop at the 1992 Leadership Conference.

the Keystone Peer Review Organization (KePRO), offered advice to help physicians deal more effectively with peer review.

In the final workshop, Richard J. Lipovich, senior manager for Arthur Andersen Healthcare Services in Pittsburgh, presented the findings of the 1991 Delphi Study, "The Future of Health Care." The study asked 2,600 health care professionals, including 1,200 physicians, what the future holds. Findings related to universal health care and costs.

From the data, Arthur Andersen developed strategies for surviving in the health care environment of the future. According to the study, Lipovich said physicians need to: 1) understand policy and payment changes; 2) select the best mode of practice; 3) look carefully at managed care organizations they may consider joining; 4) enhance productivity; 5) improve hospital relationships; and 6) strengthen patient care quality commitment. The study also suggests that hospitals make some adjustments to assure future survival, i.e., improve operational effectiveness and involve physicians in leadership roles.

SOCIETY CONDUCTING A NUMBER OF SURVEYS

Each year, the Pennsylvania Medical Society conducts a number of surveys to learn about public and member perceptions on a range of medical and public health issues. This year promises to be no different, with a dozen surveys already in the works by the Society and its Educational and Scientific Trust.

Membership surveys

An all-physician survey is conducted annually by the Society's Department of Management Information Systems. Questionnaires were mailed to all state-licensed physicians in May to collect the following data: specialty; carrier participation; years in practice; employment category (solo, partnership, hospital, group, medical school, other); and demographic/personal information. The results will be used three-fold: 1) to update the Society's database of Pennsylvania physicians; 2) to produce sections of the Society's 1992 membership directory, due in August; and 3) to compile data for the Society's Physician Manpower Report due in October.

Data for another annual survey, the Society's Membership Poll, is currently being gathered by the Trust for the Society's Division of Communications. Written questionnaires—seeking to discover members' opinions and priorities on specific issues—were mailed to a random sample of Society members and leaders beginning last month. Results are due in October.

Regulatory and public health surveys

Information about several regulatory and public health issues—including auto insurance reform, child abuse and neglect, cults, and depression in the elderly—will be collected in 1992 by the Society and the Trust.

First, in response to a Board action, an auto insurance reform survey was conducted in May and June through a written questionnaire and telephone interviews. The target audience included random samples of Pennsylvania physicians specializing in anesthesiology, general surgery, neurosurgery, neurology, orthopedic surgery, physician medicine, plastic surgery, family practice, general practice, and emergency medicine.

From the results, due in September, the Trust seeks: 1) to ascertain the level and nature of health care access problems which have resulted from the passage of the Auto Insurance Reform Act (Act 6); and 2) to collect information on physicians' experiences with the act's reimbursement limits and peer review components.

Second, the Society's Department on Education and Science will collect information on child abuse and neglect from Pennsylvania school districts. Survey questions will address school policies on child abuse, experiences with reporting child abuse, and feelings regarding Pennsylvania's child abuse and reporting laws.

Third, random samples of Pennsylvania primary care physicians and psychiatrists will be surveyed regarding cults. The study

District News

AMA VICE SPEAKER VISITS NINTH DISTRICT

Daniel H. Johnson Jr., MD, a diagnostic radiologist from New Orleans and vice speaker of the AMA House of Delegates, recently spoke at a Ninth District dinner at the invitation of Society Trustee John W. Mills, MD. More than 60 physicians attended to hear Dr. Johnson discuss content and economic aspects of Health Access America, the AMA's proposal to improve access to affordable, quality health care.

Earlier in the day, he spoke to approximately 40 members of the Hospital Medical Staff Section at Indiana County Hospital about the role of the AMA and the importance of physician involvement on a national level.



Dr. Johnson

will seek to determine specialties' experiences with and reactions to cult activities. The questionnaire is scheduled for mailing this month, and study results will be available for release to the House of Delegates in October.

Fourth, between May and September, the Trust—through focus groups and mailed written questionnaires—will collect information for the state Department of Aging to use in developing educational campaigns regarding depression in the elderly. The target audience includes physicians who specialize in family practice, general medicine, internal medicine, and geriatrics, as well as older Pennsylvanians.

Other surveys

Several other surveys are also under consideration or development:

• Four hundred randomly selected Pennsylvanians will have the opportunity to express their opinions about several medical issues through a Gallup poll. Each year the Society latches onto the poll conducted for the AMA and is given the opportunity to add questions to the survey. This year questions were added regarding medical insurance, Medicare, the cost of health care, living wills, malpractice, access to care, HIV/AIDS, substance abuse, and health care rationing. Select results will be published, for comparison purposes, with those from the Society's Membership Poll.

• State and federal government candidates will be polled through a legislative survey being conducted by the Trust. The survey will solicit opinions from the candidates on issues of interest to the Society and its members. The questionnaire will be mailed this month, and the results are slated for publication in the September issue of PENNSYLVANIA MEDICINE.

• Medical student issues will be addressed by two additional surveys under development by the Society. The first, in reponse to Resolution 91-61, will study health care coverage for Pennsylvania's medical professionals-in-training. The second, still in the proposal stages, will seek to collect information on the student loan debt load of first-year residents in the state and determine to what degree that influenced specialty choices.

• Secretaries and executives of county medical societies, under State Society bylaws, are required to file a report of disciplinary activities annually with the secretary of the Society. Questionnaires mailed on January 31, 1992, from Secretary Ferdinand L. Soission Jr., MD, were due back for tabulation by April 10. Results will be published in the secretary's report to the House of Delegates in the Society's *Official Reports Book*.

• Delegates to the 1992 House of Delegates meeting in October in Philadelphia can again look forward to completing the Annual Business Meeting Questionnaire, which is used to improve the meeting from year to year and to compile delegate interests regarding committee assignments.

The Society reminds members that these surveys are developed to obtain vital information about where to direct the Society's efforts for members, legislative action, and public well-being. Though the Society and Trust attempt to filter physicians so that they are not overburdened with surveys each year, for the reason stated above, physicians are encouraged to participate by completing as many Society surveys as possible that *do* reach their desks.

AMA News

PHYSICIANS TO SERVE ON AMA COMMITTEES

Three Pennsylvania physicians will serve on reference committees at the annual meeting of the American Medical Association's (AMA's) House of Delegates, June 21-25:

• Doris F. Bartuska, MD, will serve as chair of Reference Committee E—Science, Technology, and Public Health. She is an endocrinologist in Philadelphia.

• Jonathan E. Rhoads Jr., MD, a thoracic surgeon from York, will serve as a member of Reference Committee F—Board of Trustees. He is speaker of the Society's House.

• Jack K. Goodrich, MD, a specialist in nuclear medicine from Erie, will serve as a member of Reference Committee H—Health Care Data/ Systems. He is a delegate representing the American College of Nuclear Physicians.

Auxiliary News

AUXILIARY CONFLUENCE HELD IN APRIL

The Pennsylvania Medical Society Auxiliary held its annual confluence April 28-29 in State College. Approximately 125 members attended the mid-year educational seminar. Serving as keynote speakers were Jennie T. Stultz, director of Keep America Beautiful, Gastonia, North Carolina, who spoke on "Your Impact on the Environment"; and Sarah Weddington, an attorney from Austin, Texas, who presented, "You Can Be a Leader."

A celebrity auction highlighted Tuesday evening's program. Society Trustee Victor F. Greco, MD, served as auctioneer, and guest auctioneers from the Society included: Robert N. Moyers, MD, president; Donald G. Ferguson, MD, president elect; and John H. Hobart, MD, chairman of the board. More than $5,000 was raised for the American Medical Association Education and Research Foundation which provides money for medical schools, student loans, and community health projects. These programs are a principal objective of AMA and auxiliary activities.

The auxiliary also scheduled workshops focusing on legislative information, fund-raising, political action committees, and estate planning. Joining Dr. Moyers as guest speakers for the sessions were: R. William Alexander, MD, and Lorre Lei Jackson, board members of the Americal Medical Political Action Committee; Larry L. Light, executive director of the Pennsylvania Medical Political Action Committee; and Kenneth B. Jones, Esq., general counsel of the State Society.

FOUNDATION CREATES ACCESS INCENTIVE PROGRAM

Practice Sights, a new program of the Robert Wood Johnson Foundation (RWJF), challenges states—through collaborations among state agencies, communities, provider groups, and health professionals schools—to improve the distribution of primary care providers in medically underserved areas. Foundation staff also hope the program will help states and the nation set their sights on resolving the access problems created by the maldistribution of primary care providers.

Specifically, the work of the grantees and the partnerships under the program is intended to:

- increase the number of primary care physicians, physician assistants, nurse practitioners, and nurse midwives providing care in medically underserved areas;
- improve the reimbursement, policy, and practice environments in underserved communities so as to improve their ability to recruit and retain providers; and
- increase the state's capacity to support and enhance primary care service delivery statewide.

RWJF will make up to $16.5 million available under this four-year, two-stage competitive program. In the first stage, 15-month development grants of up to $100,000 each will be made to as many as 15 states. At the end of this development period, grantees will be eligible to

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To learn more about how to join the rapidly growing ranks of AMWA members who share your concerns, write, call, or fax the American Medical Writers Association, 9650 Rockville Pike, Bethesda Maryland 20814, (301-493-0003, fax 301-493-0005).

Just because da Vinci missed out on AMWA membership is no reason you should!

AMERICAN MEDICAL WRITERS ASSOCIATION

compete for three-year implementation grants that will average $800,000. Up to 10 states will be awarded implementation grants and will also be eligible to apply for program-related investments, averaging $700,000, to develop loan funds to enhance the viability of primary care practices.

Cabinet-level agencies in the U.S. and Puerto Rico, universities, state primary care associations, or other nonprofit groups with the capacity to develop a statewide system to support primary care providers are eligible to apply for grants. For more specific information about the program, application, selection criteria, use of funds, and evaluation and monitoring, call James D. Bernstein, program director, at (919) 821-9991.

OLDER AMERICANS SURVEYED ON LIFESTYLES

On April 1, some 250 interviewers began knocking on doors of thousands of families, asking older men and women to volunteer detailed information about their lives. The interviewers, from the University of Michigan's Institute for Social Research (ISR), plan to visit more than 13,000 older Americans across the U.S. The effort is expected to give government policymakers and researchers the data they need to better understand how people fare as they age.

Interview questions will pertain to work history; earnings, assets, and debts; pension programs and retirement incentives offered by employers; health conditions and insurance; family structure and responsibilities; housing; and current and prospective living standards. ISR expects to collect data from approximately 13,500 men and women ages 51-61 in about 80 areas across the U.S. Also, a special sample will be taken in Florida because of its high concentration of older people.

Preliminary data from the study may be available as soon as April 1993, and the study is expected to continue for at least 12 years, following up on interviewees' decisions and their health and economic well-being. The study is being sponsored by the National Institute on Aging, under a five-year cooperative agreement with the ISR.

NEW INFORMATION SERVICE AVAILABLE

A new, low-cost, on-line information service for health care professionals and others requiring access to extensive medical and health information resources is now available throug IEI Network, Inc., Wheaton, Illinois. The service, US HealthLink, provides unlimited usage of its principal products and services for one fee of $35 per month, including four hours of communications time.

Using a personal computer and communications modem, subscribers can access: medical literature from both the National Library of Medicine and Elsevier Science Publishers; up-to-the-minute medical, health, and science news; a drug interaction service; a disease information database; electronic mail and bulletin boards; and a diagnostic decision support service. Also available for an added fee are a fax information service and a premium support service.

US HealthLink offers a free, on-line preview for those with a computer, modem, and communications package. For specific information about the preview, or additional information about the service, call 1-800-682-8770.

CARDIOLOGY RELEASES

Lea and Febiger has announced the release of the following cardiology publications:

Rapid Analysis of Electrocardiograms
Written by Emanuel Stein, MD, MPH, FACP, FACC, FCCP, this 404-page, paperback book provides a firm foundation in electrocardiography for health professionals. Self-assessment is emphasized in this self-learning, programmed course, which includes questions based on the text and reflected in illustrations.

Progress in Cardiology 5/1
Written by Douglas P. Zipes, MD, this 170-page issue of the biannual publication provides the latest facts, findings, and opinions about heart disease in the elderly. Illustrations, tables, and pertinent bibliographic citations supplement the journal, which focuses on one topic of interest per issue.

For additional information or to order these publications, call Lea & Febiger at 1-800-638-0672.

PMSLIC TO OFFER SEMINAR DISCOUNT

Pennsylvania Medical Society Liability Insurance Company (PMSLIC) insureds will receive a premium discount for participation in PMSLIC's risk management seminars this fall. More details on the program, discount, and registration will appear in Society publications in the next few months. Non-PMSLIC-insured physicians will also be invited to attend, and all participants will receive Category I CME credits.

PMSLIC believes that risk management and physician participation in such educational programs will reduce the risk of malpractice litigation while improving the quality of patient care for all Pennsylvanians.

Health Department Publication

The Pennsylvania Department of Health has obtained a limited quantity of a professionally produced publication developed to assist physicians in providing clinical care to people with HIV infection. For information about obtaining one free copy of the publication, call the department's Bureau of HIV/AIDS at (717) 783-0572. Orders must be placed by June 30, 1992.

Reach Out to Colleagues Where? How?

Place a message in the 1992 Membership Directory of the Pennsylvania Medical Society.

Deadline for insertion orders for advertising space is June 26. Call (717) 558-7750.

Ralph Gaudio Jr., MD, internal medicine and pulmonary disease specialist at North Hills Passavant and Suburban General hospitals in Pittsburgh, received a Physicians Merit Award from the Allegheny County Medical Society for his tireless work and contributions.

John Silverio, MD, FAAP, FACN, retired after three decades as director of pediatric nutrition research at Wyeth-Ayerst Laboratories. Based on his accomplishments in infant nutrition, the Association of Medical School Pediatric Department Chairmen have established the "John Silverio Pediatric Research Fellowship Award" to be given annually.

Lila Stein Kroser, MD, a family medicine practitioner in northeast Philadelphia and faculty member at the Medical College of Pennsylvania, was re-elected treasurer of the Medical Women's International Association. She also serves as a director of the Philadelphia County Medical Society and the Pennsylvania Academy of Family Physicians.

Paul E. Berkebile, MD, anesthesiologist at Allegheny General Hospital, has been named president elect of the American Heart Association, Pennsylvania affiliate.

Robert J. Jenkins, MD, an internal medicine specialist in Finleyville, was elected to the Board of Directors of Mon-Vale Health Resources, Inc., in Carroll Township.

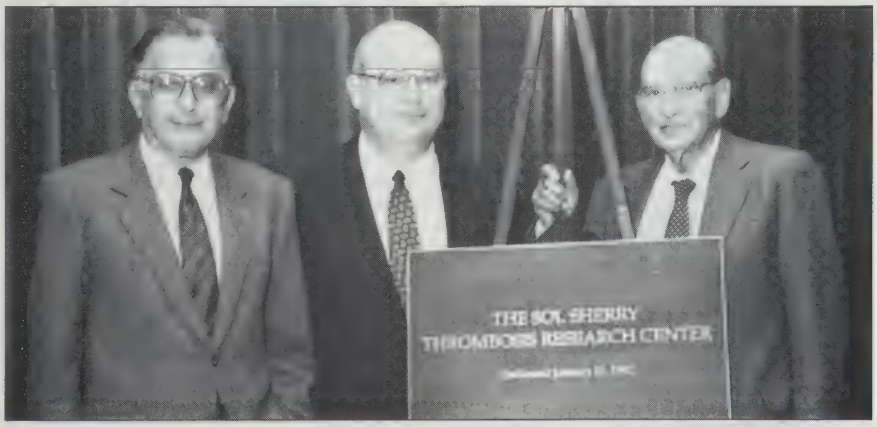


Lynda Thomas, MD (center), an obstetrician at Chestnut Hill Hospital in Philadelphia, and her mother, Audrey (left), were recognized by the U.S. Surgeon General Antonia Novello, MD (right), in a special ceremony for families of organ and tissue donors. Dr. Thomas's son, who died last August, was an organ and tissue donor, helping to save the lives of several people. Dr. Thomas was recognized for her "supreme humanitarian spirit to give the Gift of Life to others" by consenting to organ donation.

Jules Kann, MD, PhD, internal medicine specialist in Pittsburgh, was honored by the Pennsylvania Senate with a citation for his contributions to the Pennsylvania Chronic Fatigue Association.

Joseph A. Marasco, MD, Pittsburgh radiologist, was elected treasurer of the International Society of Radiology.

Kenneth L. Cooper, MD, retired medical director of the Family Planning Center, Williamsport Hospital, was honored by the Lycoming County Chapter of the National Conference of Christians and Jews for his longtime service as a civic leader.



Temple University has named its Thrombosis Research Center after Sol Sherry, MD (right), in honor of his many contributions to the hospital and school of medicine. Pictured with Dr. Sherry are (left-right): Peter J. Liacouras, president of Temple University, and Leon S. Malmud, MD, vice president of Temple University Health Sciences Center. In other news from Temple, Dr. Malmud has been elected to fellowship in the American College of Nuclear Physicians.

Robert P. Liss, MD, specialist in anterior segment ophthalmology and associate clinician at the Scheie Eye Institute at the University of Pennsylvania, was selected as an instructor of cataract surgery at the 1992 American Academy of Ophthalmology's Annual Meeting in Dallas, Texas.

Rex H. Newton, MD, chief, Department of Physical Medicine and Rehabilitation, Harmarville Rehabilitation Center, Pittsburgh, was selected 1991 Physician of the Year by the National Association of Rehabilitation Professionals in the Private Sector.

Barry B. Goldberg, MD, director, Division of Ultrasound, Department of Radiology, Thomas Jefferson University Hospital, received the Joseph H. Holmes Clinical Pioneer Award from the American Institute of Ultrasound in America for his contribution to the development of diagnostic ultrasound.

Joseph C. Flanagan, MD, director of oculoplastic service, Wills Eye Hospital, Philadelphia, in March presented "Endoscopic Laser DCRs" as the featured speaker at Grand Rounds at the Cornell Medical Center in New York City.

Anthony R. Temple, MD, Wayne, has been promoted to executive director, medical, and named to the management board at McNeil Consumer Products Company in Fort Washington.

Howard K. Rabinowitz, MD, professor and vice chairman, Department of Family Medicine, Jefferson Medical College, Philadelphia, was elected president of the American Board of Family Practice.

John C. Sonne, MD, Moorestown, New Jersey, received the Bion Award for Distinguished Scientific Achievement in Psychoanalysis, presented by the Study Group for Contemporary Psychoanalytic Process at the Institute of the Pennsylvania Hospital in Philadelphia. Also, Dr. Sonne recently presented "The Relevance of the Dread of Being Aborted to Models of Therapy and Models of the Mind" at a Tuesday Conference of the Institute.

The following were elected officers by the medical staff at Tyler Memorial Hospital in Tunkhannock: **Ian A. Kellman, MD,** director of radiology, as president; **John C. Gardner, MD,** family practice physician, as vice president; and **Donald L. Jackson, MD,** director of emergency medicine, as secretary-treasurer.

Harry G. Zegel, MD, attending physician in medical imaging at Presbyterian Medical Center, is assuming two additional positions at Presbyterian: vice chairman of the Department of Medical Imaging and director of its Radiology Residency/Fellowship Program.

Paul R. Rosenberg, MD, Pittsburgh specialist in diseases of the retina, was elected to fellowship in the American College of Surgeons.

David Yanoff, MD, private practice thoracic surgeon, was appointed to the board of directors at Gnaden Huetten Memorial Hospital in Lehighton.

DeWitt E. Kemp III, MD, director of the regional hospice at Windber Hospital, was elected president of the hospital's medical staff.

M.H.V. Murthy, MD, FACP, medical staff director at Suburban General Hospital in Pittsburgh, was elected to fellowship in the American College of Physicians.

Jorge Lindenbaum, MD, internal medicine specialist, was named president of the medical staff at Divine Providence Hospital of Pittsburgh. Also at Divine Providence, **Thomas W. Cowan, MD,** orthopedic surgeon, was appointed chair of the Department of Surgery; and **Anthony P. Yates, MD,** internal medicine specialist, was appointed chair of the Department of Medicine.

Rodolfo I. Godinez, MD, PhD, medical director of the Department of Respiratory Care Services and associate director of the Pediatric Intensive Care Complex of the Children's Hospital of Philadelphia, was elected to a three-year term on the board of directors of the American Society for Testing and Materials.

The following physicians were elected staff officers at Grand View Hospital in Sellersville: **Mitchell J. Barrer, MD,** as medical staff president; **Irwin J. Hollander, MD,** as vice president; **Sandra Harris-Corrado, MD,** as secretary/treasurer; and **Ann M. Rudden, MD,** as member-at-large of the medical executive committee. Dr. Hollander was also elected respresentative to the Hospital Medical Staff Section of the State Society.

Paul D. Thompson, MD, was named director of the newly formed Cardiovascular Disease Prevention Center at the University of Pittsburgh Medical Center Heart Institute.

Newell Fischer, MD, senior attending psychiatrist at The Institute of Pennsylvania Hospital in Philadelphia, received first place status in the Ralph B. Little Award for Clinical Research in Psychiatry for his paper, "The Psychoanalytic Experience and Psychic Change." Institute medical staff members **Marcia Meckler, MD,** and **Silas L. Warner, MD,** received second-place status, and honorable mentions went to: **Sydney Pulver, MD; Ira Brenner, MD; Howard S. Baker, MD;** and **Michael Miller, MD**.

Juan A. Asensio, MD, Philadelphia, has been appointed associate professor of surgery and chief of the Division of Trauma Surgery and Surgical Critical Care at Hahnemann University. Dr. Asensio will also serve as medical director of Hahnemann's Level I Regional Resource Trauma Center, as well as of its University MedEvac.

Francis L. Hutchins Jr., MD, clinical associate professor of obstetrics/gynecology at Hahnemann University Hospital and Thomas Jefferson University Hospital, was appointed director of the Division of Gynecology and Women's Services at the Graduate Hospital in Philadelphia.



Dr. Hutchins

Donald G. Mitchell, MD, associate professor of radiology and director of the Division of Magnetic Resonance Imaging, Thomas Jefferson University, was recognized by the Association of University Radiologists for the paper, "Chemical Shift Phase-Difference and Suppression Magnetic Resonance Imaging Techniques in Animals, Phantoms, and Humans." Dr. Mitchell wrote the paper with colleagues at Jefferson.

Eric N. Faerber, MD, was named director of the Department of Radiology at St. Christopher's Hospital for Children, Philadelphia.

George W. Blankenship Jr., MD, professor and chairman of ophthalmology, Penn State's Milton S. Hershey Medical Center, was promoted to associate dean for external affairs and continuing medical education.

The following were appointed to positions at the Graduate Hospital in Philadelphia: **Vincent M. Vaccaro, MD,** Newtown Square, as director of benign gynecology; **Harry Reich, MD, FACOG,** Dallas, as director of gynecologic surgery; and **Michael J. Campion, MD,** Villanova, as director of clinical research.

Bartley P. Griffith, MD, a Henry T. Bahnson professor and chair in cardiothoracic surgery, University of Pittsburgh Medical Center, received a University Medalion honoring him as the second holder of the Bahnson Chair and for his contributions to heart and lung surgery, and organ transplantation.

Jonas T. Johnson, MD, FACS, professor and vice chairman, director, Division of Head and Neck Oncology and Immunology, Department of Otolaryngology, University of Pittsburgh School of Medicine, has been appointed editor-in-chief of the *American Journal of Otolaryngology*.

Herbert S. Waxman, MD, chairman of medicine, Albert Einstein Medical Center, and professor of medicine, Temple University School of Medicine, has been named president elect of the Association of Program Directors in Internal Medicine.

William S. Frankl, MD, Wynnewood, has been appointed regional director of cardiovascular services for Medical College Hospitals, Philadelphia. Dr. Frankl will also serve as professor of medicine at the Medical College of Pennsylvania.

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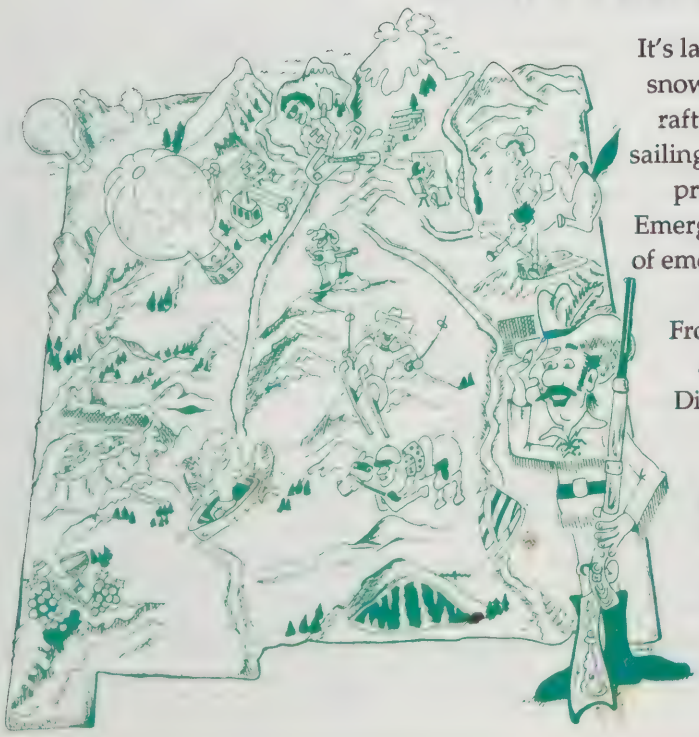
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Responding to Living Wills: Questions for Physicians

William Cooper, MD, JD

Most people have concern for that period when death begins but life continues—that period when our control of our life situation is lessened or lost. One of the first recorded discussions of this matter was by Aristotle in his proposal for the Necomachean Ethics: he proposed that fairness in dealings with others be the basis of all relationships.

Mills, in 1907, proposed the Utilitarian Ethic, where the good to the individual was reviewed in light of its effect on the good to the group. The effect on the group dominated, and individuals' rights were—to some degree—lessened. This approach has been used in recent years to justify certain rationing decisions. Wasserman, in his writing in the Hastings Center Report (October 1983), said, "When a patient's only connection to life is through a respirator or an IV tube, the length of life should not be determined by the amount—or the duration—of Medicare benefits."

Dr. Louis Kutner is given credit for the first use of the term, "living will" in 1967 in a discussion regarding patients' wishes. In 1969 he published an article in the *Indiana Law Journal* proposing legislation for the same. Since that time, 48 states have enacted some legislation regarding the "living will," and 49 jurisdictions have durable power of attorney provisions. Additionally, some states have indicated the availability of specific durable power of attorney for health affairs.

Patients write living wills and durable powers of attorney for a number of reasons, and the physician's responsibilities are numerous when the patient has correctly completed one of these documents. Physicians should know:

1) procedural requirements to implement these documents, as these may vary from state to state and according to which document is available to the patient;

2) requirements within their jurisdictions, such as duration of validity of the documents, reaffirmation requirements upon hospital admission, revocation requirements, or degree of immunity conferred on physicians; and

3) how to respond to advance directive or family or state conflicts.

One such conflict is the definition of medical futility. If a treatment merely preserves permanent unconsciousness or cannot end dependence upon extensive medical supportive care, it should be considered medically futile. This is a professional judgement that takes precedence over patient autonomy. (For discussion, see Schneiderman et. al., *Ann Int Med*, 112:12, 1990.)

Physicians must also consider the many questions provoked by the existence of living wills and durable powers of attorney for health care: Do patient rights extend to the provision of futile therapy? Does the institution or do patients and families have the right to demand treatments that do not result in improvement in effective life span, but simply extend the dying period? Can the currently terminally ill, incompetent, and hopelessly ill have support systems withdrawn? Is it a medical decision or a social decision requiring input from ethics committees or the judical system?

I recommend that in addition to asking these questions, physicians continue to not only provide living will and durable power of attorney documents and information to patients, but also attempt to change the emphasis from death in the institution to the "art of dying well." In ancient Rome, the art of dying well was fostered by Seneca and his students. Such a lesson could help family and friends, but will require increased funding and health professional support for home care for the terminally ill.

Dr. Cooper is chairman emeritus, Department of Medicine, at Shadyside Hospital, Pittsburgh.



WHEN ACID REFLUX ERUPTS

Zantac® 150 Tablets **BRIEF SUMMARY**
(ranitidine hydrochloride)

Zantac® 300 Tablets
(ranitidine hydrochloride)

Zantac® Syrup
(ranitidine hydrochloride)

The following is a brief summary only. Before prescribing, see complete prescribing information in Zantac® product labeling.

INDICATIONS AND USAGE: Zantac® is indicated in:
1. Short-term treatment of **active duodenal ulcer.** Most patients heal within 4 weeks.
2. **Maintenance therapy** for duodenal ulcer patients at reduced dosage after healing of acute ulcers.
3. The treatment of **pathological hypersecretory conditions** (e.g., Zollinger-Ellison syndrome and systemic mastocytosis).
4. Short-term treatment of **active, benign gastric ulcer.** Most patients heal within 6 weeks and the usefulness of further treatment has not been demonstrated.
5. Treatment of **gastroesophageal reflux disease (GERD).** Symptomatic relief commonly occurs within 1 or 2 weeks after starting therapy. Therapy for longer than 6 weeks has not been studied.

In active duodenal ulcer; active, benign gastric ulcer; hypersecretory states; and GERD, concomitant antacids should be given as needed for relief of pain.

CONTRAINDICATIONS: Zantac® is contraindicated for patients known to have hypersensitivity to the drug.

PRECAUTIONS:

General: 1. Symptomatic response to Zantac® therapy does not preclude the presence of gastric malignancy.
2. Since Zantac is excreted primarily by the kidney, dosage should be adjusted in patients with impaired renal function (see DOSAGE AND ADMINISTRATION). Caution should be observed in patients with hepatic dysfunction since Zantac is metabolized in the liver.

Laboratory Tests: False-positive tests for urine protein with Multistix® may occur during Zantac therapy, and therefore testing with sulfosalicylic acid is recommended.

Drug Interactions: Although Zantac has been reported to bind weakly to cytochrome P-450 *in vitro,* recommended doses of the drug do not inhibit the action of the cytochrome P-450-linked oxygenase enzymes in the liver. However, there have been isolated reports of drug interactions that suggest that Zantac may affect the bioavailability of certain drugs by some mechanism as yet unidentified (e.g., a pH-dependent effect on absorption or a change in volume of distribution).

Increased or decreased prothrombin times have been reported during concurrent use of ranitidine and warfarin. However, in human pharmacokinetic studies with dosages of ranitidine up to 400 mg per day, no interaction occurred; ranitidine had no effect on warfarin clearance or prothrombin time. The possibility of an interaction with warfarin at dosages of ranitidine higher than 400 mg per day has not been investigated.

Carcinogenesis, Mutagenesis, Impairment of Fertility: There was no indication of tumorigenic or carcinogenic effects in lifespan studies in mice and rats at dosages up to 2,000 mg/kg per day.

Ranitidine was not mutagenic in standard bacterial tests (*Salmonella, Escherichia coli*) for mutagenicity at concentrations up to the maximum recommended for these assays.

In a dominant lethal assay, a single oral dose of 1,000 mg/kg to male rats was without effect on the outcome of two matings per week for the next 9 weeks.

Pregnancy: ***Teratogenic Effects: Pregnancy Category B:*** Reproduction studies have been performed in rats and rabbits at doses up to 160 times the human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Zantac. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: Zantac is secreted in human milk. Caution should be exercised when Zantac is administered to a nursing mother.

Pediatric Use: Safety and effectiveness in children have not been established.

Use in Elderly Patients: Ulcer healing rates in elderly patients (65 to 82 years of age) were no different from those in younger age-groups. The incidence rates for adverse events and laboratory abnormalities were also not different from those seen in other age-groups.

ADVERSE REACTIONS: The following have been reported as events in clinical trials or in the routine management of patients treated with Zantac®. The relationship to Zantac therapy has been unclear in many cases. Headache, sometimes severe, seems to be related to Zantac administration.

Central Nervous System: Rarely, malaise, dizziness, somnolence, insomnia, and vertigo. Rare cases of reversible mental confusion, agitation, depression, and hallucinations have been reported, predominantly in severely ill elderly patients. Rare cases of reversible blurred vision suggestive of a change in accommodation have been reported.

Cardiovascular: As with other H_2-blockers, rare reports of arrhythmias such as tachycardia, bradycardia, atrioventricular block, and premature ventricular beats.

Gastrointestinal: Constipation, diarrhea, nausea/vomiting, abdominal discomfort/pain, and rare reports of pancreatitis.

Hepatic: In normal volunteers, SGPT values were increased to at least twice the pretreatment levels in 6 of 12 subjects receiving 100 mg q.i.d. intravenously for 7 days, and in 4 of 24 subjects receiving 50 mg q.i.d. intravenously for 5 days. There have been occasional reports of hepatitis, hepatocellular or hepatocanalicular or mixed, with or without jaundice. In such circumstances, ranitidine should be immediately discontinued. These events are usually reversible, but in exceedingly rare circumstances death has occurred.

Musculoskeletal: Rare reports of arthralgias.

Hematologic: Blood count changes (leukopenia, granulocytopenia, thrombocytopenia) have occurred in a few patients. These were usually reversible. Rare cases of agranulocytosis, pancytopenia, sometimes with marrow hypoplasia, and aplastic anemia and exceedingly rare cases of acquired immune hemolytic anemia have been reported.

Endocrine: Controlled studies in animals and man have shown no stimulation of any pituitary hormone by Zantac® (ranitidine HCl) and no antiandrogenic activity, and cimetidine-induced gynecomastia and impotence in hypersecretory patients have resolved when Zantac has been substituted. However, occasional cases of gynecomastia, impotence, and loss of libido have been reported in male patients receiving Zantac, but the incidence did not differ from that in the general population.

Integumentary: Rash, including rare cases suggestive of mild erythema multiforme, and, rarely, alopecia.

Other: Rare cases of hypersensitivity reactions (e.g., bronchospasm, fever, rash, eosinophilia), anaphylaxis, angioneurotic edema, and small increases in serum creatinine.

OVERDOSAGE: Information concerning possible overdosage and its treatment appears in the full prescribing information.

DOSAGE AND ADMINISTRATION: (See complete prescribing information in Zantac® product labeling.)

Active Duodenal Ulcer: The current recommended adult oral dosage is 150 mg or 10 mL (2 teaspoonfuls equivalent to 150 mg of ranitidine) twice daily. An alternate dosage of 300 mg or 20 mL (4 teaspoonfuls equivalent to 300 mg of ranitidine) once daily at bedtime can be used for patients in whom dosing convenience is important. The advantages of one treatment regimen compared to the other in a particular patient population have yet to be demonstrated.

Maintenance Therapy: The current recommended adult oral dosage is 150 mg or 10 mL (2 teaspoonfuls equivalent to 150 mg of ranitidine) at bedtime.

Pathological Hypersecretory Conditions (such as Zollinger-Ellison syndrome): The current recommended adult oral dosage is 150 mg or 10 mL (2 teaspoonfuls equivalent to 150 mg of ranitidine) twice a day. In some patients it may be necessary to administer Zantac® 150-mg doses more frequently. Dosages should be adjusted to individual patient needs, and should continue as long as clinically indicated. Dosages up to 6 g per day have been employed in patients with severe disease.

Benign Gastric Ulcer: The current recommended adult oral dosage is 150 mg or 10 mL (2 teaspoonfuls equivalent to 150 mg of ranitidine) twice a day.

GERD: The current recommended adult oral dosage is 150 mg or 10 mL (2 teaspoonfuls equivalent to 150 mg of ranitidine) twice a day.

Dosage Adjustment for Patients with Impaired Renal Function: On the basis of experience with a group of subjects with severely impaired renal function treated with Zantac, the recommended dosage in patients with a creatinine clearance less than 50 mL/min is 150 mg or 10 mL (2 teaspoonfuls equivalent to 150 mg of ranitidine) every 24 hours. Should the patient's condition require, the frequency of dosing may be increased to every 12 hours or even further with caution. Hemodialysis reduces the level of circulating ranitidine. Ideally, the dosing schedule should be adjusted so that the timing of a scheduled dose coincides with the end of hemodialysis.

HOW SUPPLIED: Zantac® 300 Tablets (ranitidine hydrochloride equivalent to 300 mg of ranitidine) are yellow, capsule-shaped tablets embossed with "ZANTAC 300" on one side and "Glaxo" on the other. They are available in bottles of 30 (NDC 0173-0393-40) tablets and unit dose packs of 100 (NDC 0173-0393-47) tablets.

Zantac® 150 Tablets (ranitidine hydrochloride equivalent to 150 mg of ranitidine) are white tablets embossed with "ZANTAC 150" on one side and "Glaxo" on the other. They are available in bottles of 60 (NDC 0173-0344-42) and 100 (NDC 0173-0344-09) tablets and unit dose packs of 100 (NDC 0173-0344-47) tablets.

Store between 15° and 30°C (59° and 86°F) in a dry place. Protect from light. Replace cap securely after each opening.

Zantac® Syrup, a clear, peppermint-flavored liquid, contains 16.8 mg of ranitidine hydrochloride equivalent to 15 mg of ranitidine per 1 mL in bottles of 16 fluid ounces (one pint) (NDC 0173-0383-54).

Store between 4° and 25°C (39° and 77°F). Dispense in tight, light-resistant containers as defined in the USP/NF.

September 1991

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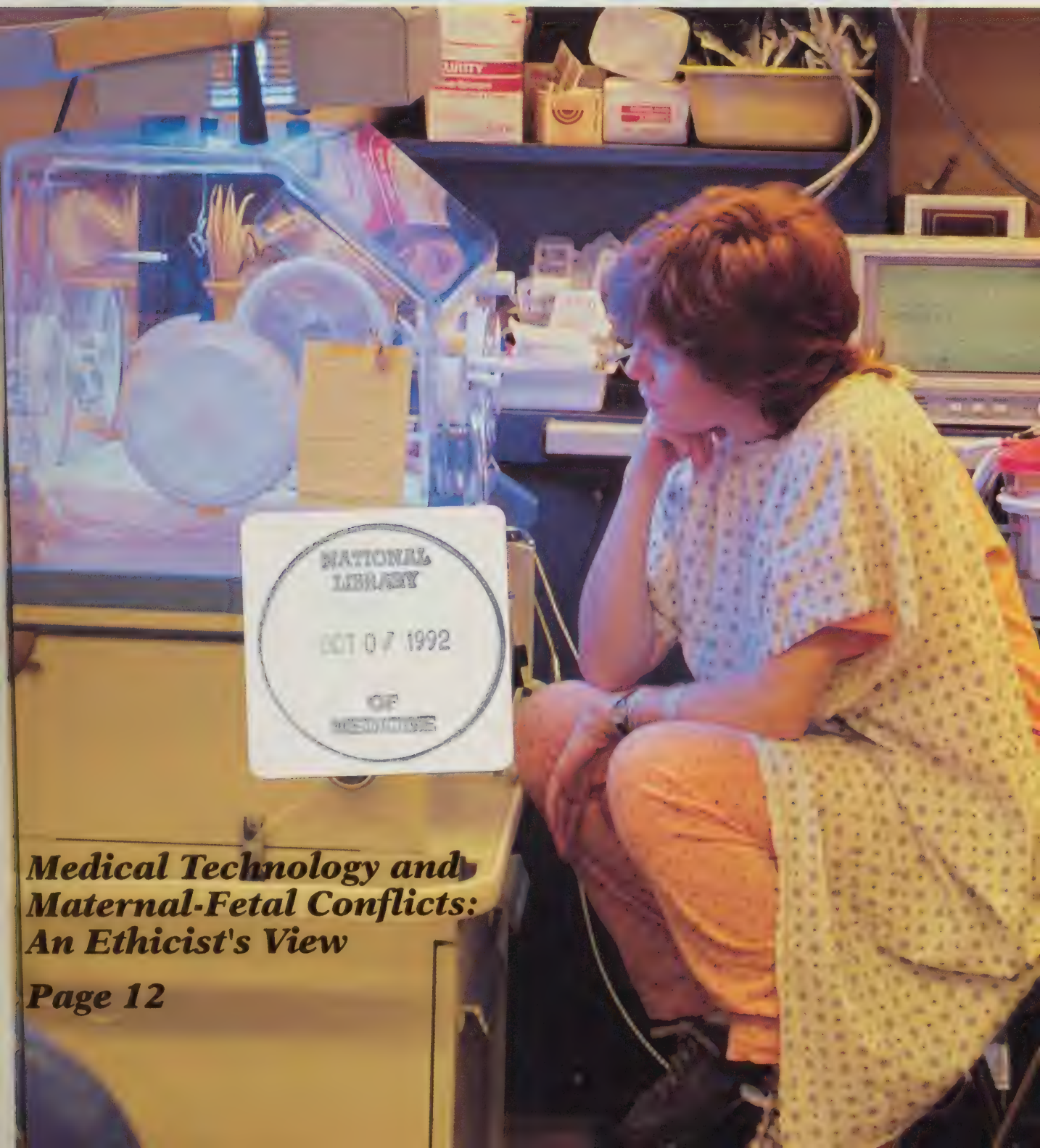
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Zantac® Tablets
ranitidine HCl/Glaxo 150 mg tablets bid
WHEN ACID REFLUX ERUPTS
Please see Brief Summary of Prescribing Information on adjacent page.
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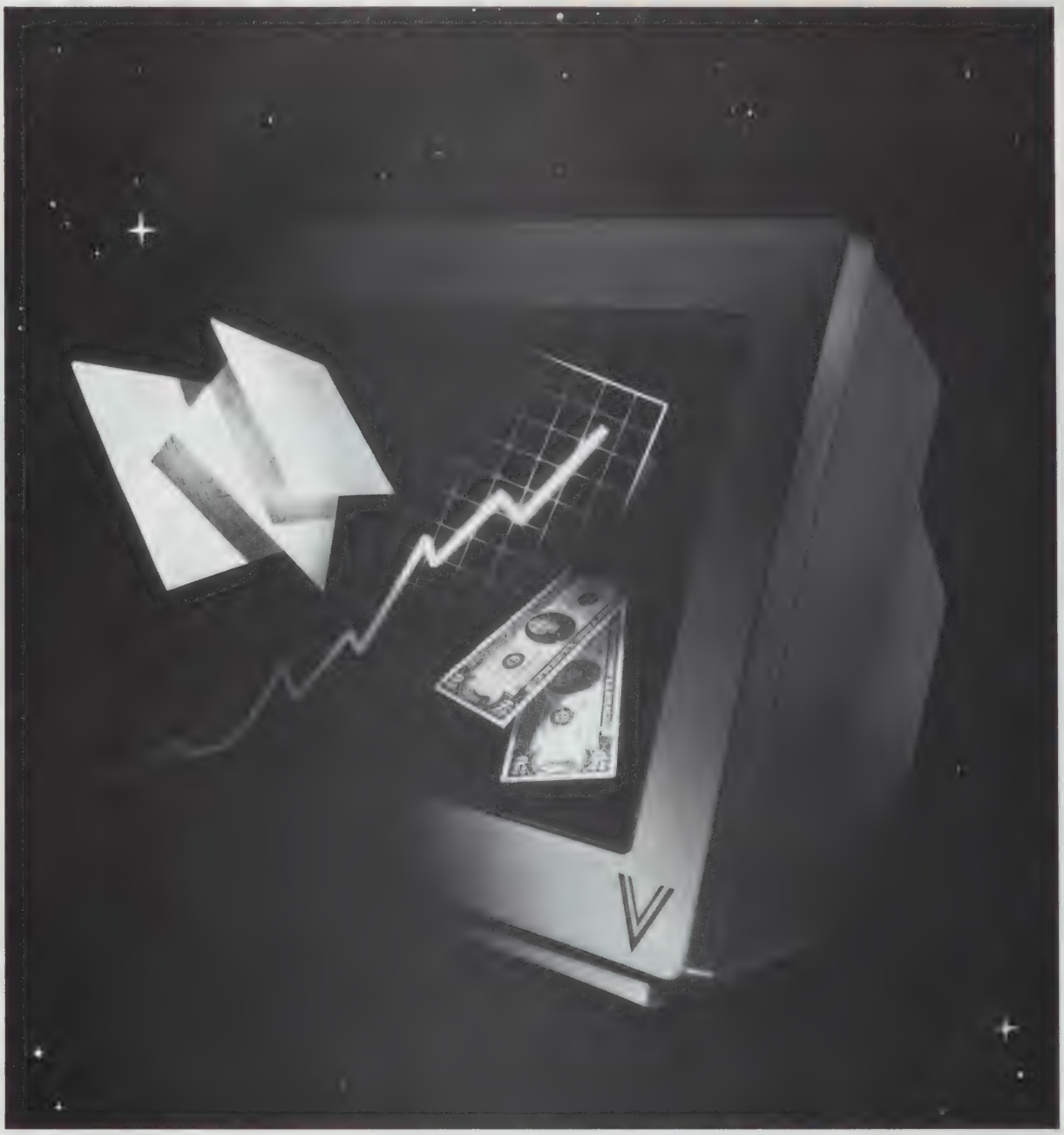


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Medical Technology and Maternal-Fetal Conflicts: An Ethicist's View

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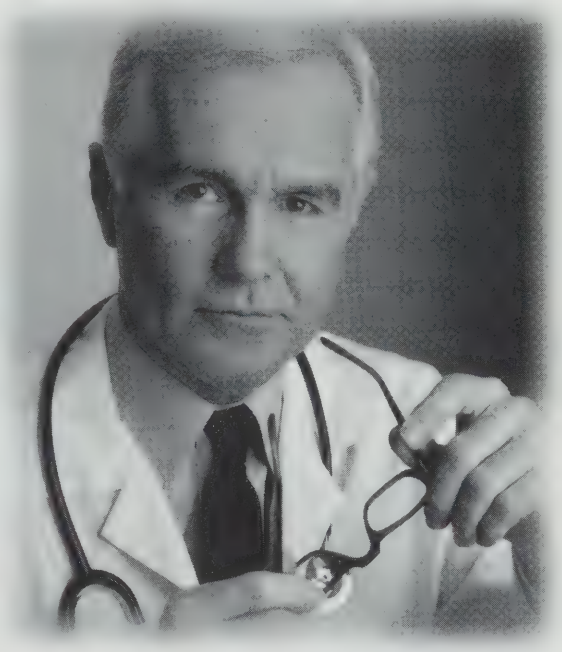
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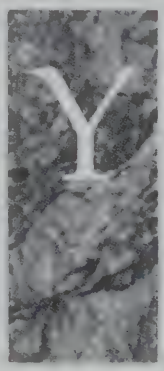
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PENNSYLVANIA MEDICINE (ISSN 0031-4595) is published monthly by the Pennsylvania Medical Society, 777 East Park Drive, Harrisburg, PA 17111.
SUBSCRIPTIONS: $20 per year— United States and Canada; $30—all others. Single issues $3.00 per copy prepaid; special issues cost more.
POSTMASTER: Send address changes to PENNSYLVANIA MEDICINE, 777 East Park Drive, PO Box 8820, Harrisburg, PA 17105–8820. Second class postage paid at Harrisburg, PA 17105.



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MEDIGRAM

WORKERS' COMP BILL AMENDED, MEDICAL LANGUAGE UNTOUCHED: The state Senate on June 30 passed (30-18) an amended version of House Bill 2140, addressing workers' compensation reform. The bill's medical language—limiting medical payments to 120 percent of the Medicare allowance for 1992 and offering an annual update beginning in 1993 equal to the percentage change in the statewide average weekly wage—was comparable to the previous Senate-passed version. Since the Senate vote occurred during a House recess, the House will not consider the bill until it reconvenes September 21. The Senate procedural maneuvers avoided a conference committee on the bill.

HOUSE COMMITTEE APPROVES CERTIFICATE OF NEED LEGISLATION: The House Health and Welfare Committee in late June voted 13-10 in support of House Bill 1982, which modifies Pennsylvania's Certificate of Need (CON) program. The program could sunset December 31, 1992, a move the State Society supports because improvement in quality of care and limiting increased health care costs, with few exceptions, have not resulted from the program as intended. The Society's Board in May adopted a recommendation advocating assurance of quality through appropriate licensure standards, but Society lobbyists are working with key legislators in an attempt to amend the bill should it pass.

HOUSE PASSES MAMMOGRAPHY BILL: Pennsylvania's House of Representatives, just prior to recess on June 30, passed (196-1) Senate Bill 1939, the Mammography Quality Assurance Act. The bill—introduced by Senator Allyson Schwartz (D-Philadelphia), and supported by the Society and the Pennsylvania Radiological Association—establishes standards for mammography services. The Senate unanimously passed the bill on May 19, at which time it was amended to utilize federal Medicare standards in lieu of those set by the American College of Radiology. At press time, the bill was back in the Senate for concurrence on the House amendments, and action was pending.

SOCIETY MEMBERS ELECTED TO AMA POSTS: Pennsylvanians will play an increasingly prominent role in organized medicine at the national level with the election of three State Society members to posts at the American Medical Association (AMA): Society President Robert N. Moyers, MD, a Meadville family physician, was elected to a three-year term on the Council on Medical Education; Lee H. McCormick, MD, a Pittsburgh family physician, was elected to a two-year term as chairman of the governing council of the AMA's Hospital Medical Staff Section; and Maria Simbra, who just completed her third year at the University of Pittsburgh School of Medicine, was elected to a one-year term as chairman of the governing council of the AMA's Medical Student Section. Elections were held in conjunction with the AMA's annual meeting in June.

CONCERN ABOUT PHYSICIAN LIABILITY UNDER ADA EXPRESSED: Several State Society members have expressed concern about their liability under the Americans With Disabilities Act (ADA) when they perform physicial examinations at an employer's request. In particular, they are concerned about the inclusion in their reports of information with respect to medical history or previous workers' compensation claims. According to an attorney from the Equal Employment Opportunity Commission (EEOC), a physician who performs examinations in a "medically ethical manner" should not be exposed to liability for a report and advice given to an employer. The ADA prohibits the *employer* from making employment decisions based on a person's handicap or disability and requires the *employer* to segregate medical information from general personnel records. It appears, at the present time, that physicians' liability under the ADA is primarily focused on their role as employers and the accessibility of their offices to the public.

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AIDS: Startling Statistics Call for Strong Actions

John W. Mills, MD
Medical Editor

"If we continue to pussyfoot around this epidemic, we will be consumed by it."

A public service message on TV recently pointedly announced that one in 250 Americans are infected with HIV. There followed a toll-free number for "information on how to prevent HIV infection."

That statistic boggled my mind: one in 250 Americans infected with HIV? Is this true? In a recent editorial I questioned whether the Centers for Disease Control (CDC) is telling the truth about HIV; now I question it even more. I recalled Mark Twain's comment, "Statistics and more statistics and damn lies." But this startling statistic, true or not, pulled me toward several realizations.

The new regulations from the Occupational Safety and Health Administration (OSHA) on controlling bloodborne pathogens in medical facilities have jump-started physicians and their office staffs into compliance under the threat of severe fines. As I said in a recent editorial, I think the regulations are probably a good thing—though perhaps misdirected.

That misdirection is the problem. The federal regulators have missed the boat with their emphasis so far; past efforts in the right direction have not been carried through. Former Surgeon General C. Everett Koop sent an HIV informational flyer to each American household several years ago. It was a well-intentioned effort which should have been continued on a periodic basis with new information and updated statistics. This would have been a very positive way to disseminate HIV trends and keep the spector of HIV before the American public so that we could begin to really understand the seriousness of this scourge.

Instead, federal efforts turned toward us—the medical community.

Most physicians would argue for HIV infection to be treated as an infectious disease, reportable at once with immediate follow-up of patient contacts. Unfortunately, the legal morass in this country, spurred on by AIDS activists, have made this deadly disease a political football. Even with the increasingly alarming spread to the heterosexual population and to teenagers, we are afraid or blinded by the threat of legal actions to call a spade a spade.

Physicians know that, regardless of OSHA's newest regulations, the threat of spreading HIV infection from within our offices is a miniscule risk.

Rather, the federal regulations need to acknowledge the actual modes of infection and get tough about dealing with them.

It is a sexually transmitted disease as well as an illicit drug user's disease. It should be immediately reportable with follow-up with patient contacts.

If we continue to pussyfoot around this epidemic, we will be consumed by it.

Education is our other tool. We need widespread sex education, including information on HIV and other sexually transmitted diseases. This should be mandatory in the schools starting in the elementary grades and continuing through college. We can't afford not to spend this effort to protect our young citizens from themselves.

Some might blame our dilemma on the breakdown of morality in this country. They're not entirely wrong, in my view: the sexual revolution of the 1960s was part of that breakdown. Couple this with the increasing loss of the family unit, and you have the seeds of destruction. But when the rights of some threaten the health of a nation, it's time for action. The common good should be the legal precedent here.

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MIIX President

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Notes from the Road

Robert N. Moyers, MD

"Physicians should be players, because we know the business of medicine as well as the art of providing effective medical care."



Feeling a little like a traveling preacher intent on spreading the word, I rolled out on my first hospital medical staff visit to Bryn Mawr in late January. My truck odometer read 80,000 miles. More than two dozen visits later, it reads 120,000 miles. Many more miles are represented in plane flights and in the company of Society staff as a tired and grateful passenger.

By the time my presidency is over, I will have spoken personally to hundreds of physicians, averaging two visits a week to county medical societies and hospital medical staff meetings. That's in addition to many, many visits to Harrisburg to talk to groups ranging from the foundrymen to legislators, and several trips to Washington. It's been a privilege. It's been a challenge. But it's just a beginning.

It's been my longtime goal to reach out to our colleagues who are not members and give them the very compelling reasons to join us in our efforts. We know there are a number of external forces that are affecting the way we practice medicine. Two key forces are governmental regulation and legislative activity. We in the Society, and I as president, recognize the feelings of concern, frustration, anger, and disillusionment that these forces elicit in physicians.

If we as a profession want to do something about these negative forces, we need to become more effective and influential. We must unify in the only association that serves us all regardless of specialty, the Pennsylvania Medical Society.

But unity is not enough. There is little value in a society that functions only as a loose association of political observers or bystanders. The State Society needs not only more members, but more member involvement. Many are active; many more must be, particularly in the legislative process and in devising ways in which we can have an impact on that process.

I've put a lot of rubber to the road to take this message to physicians. There's no way around it. Each of us must devote a bit of time to addressing the issues of the day. We must learn to communicate better with our legislators.

My travels throughout the state have reinforced my belief that physicians do not have to be victims of this whole process. We do need to get a better grasp on how to deal with the legislative process effectively and strengthen our ability to influence legislation. This is especially critical as the nation and its individual states struggle with health care reform. Physicians should be players, because we know the business of medicine as well as the art of providing effective medical care.

When physicians' input is lost, our health care system is vulnerable to special interest groups who may want only to control costs by sacrificing quality, and to the quick fix that can become the long-term boondoggle. We can play a more aggressive role in this whole process, or we can become victims of others' decisions, mere purveyors of care at the control of others.

My visits to hospital medical staff sections, in addition to the regular visits to county medical societies, are part of an initial effort to achieve greater unity. Many physicians tell me they want to see more regular outreach programs at the local level.

This certainly reinforces my impression that the Society needs a greater presence on the front lines of the medical care delivery system. It's important that members and non-members have the opportunity to meet and talk to Society leadership and staff. We must be more than just names and faces in Harrisburg. Physicians need to see that there really are people who are concerned about working to solve our mutual problems.

I'm more determined than ever to see how we can be more helpful in rebuilding our sense of professionalism, improving our scope of influence, and expanding our role as patient advocates. I'm confident that more leaders and members will join me, on the road again....



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VACCINE PAMPHLET SUPPLEMENT RELEASED

In mid-March 1992, the Pennsylvania Department of Health sent to each Pennsylvania Medical Society member (who was likely to administer childhood vaccines) a camera-ready copy of three different Vaccine Information Pamphlets (VIPs) developed by the Centers for Disease Control (CDC). The VIPs—for use with DTP, OPV, and MMR vaccines—would satisfy a provision of the National Childhood Vaccine Injury Act (Public Law 99-660).

Because of the recent licensure of the acellular pertussis vaccine, a supplement was developed for the VIP that is used with DTP vaccine. *This VIP Supplement must be inserted into the DTP pamphlet, if the DTP vaccine being used by the health care provider was purchased using the federal vaccine contract.* Even though few physicians would be required to use the supplement, many are using the VIPs developed by the CDC and, therefore, are encouraged, but not required, to use the supplements when they administer any DTP vaccine.

Enclosed is a copy of the VIP supplement. In communications with Society members, it might be helpful for them to know about this. Thank you for your assistance.

Robert E. Longenecker
Immunization Program Coordinator
Pennsylvania Department of Health
Harrisburg

Editor's Note: At right is a reprint of the supplement which physicians may copy, cut, and insert into DTP pamphlets as needed. The State Society, in an early June news release, expressed some concern with the CDC pamphlets: "A major concern is that [the government's] effort to provide so much detail, on what for most families has been routine preventive health care, can backfire, actually scaring parents away from having their children immunized," warned Society President Robert N. Moyers, MD, a family physician. Also, May's American Academy of Pediatrics "AAP News" reports that many parents refuse to read the booklets, and many who do "are frightened." The distribution of the information specified by the National Childhood Vaccine Injury Act should be in addition to routine pre-immunization counseling, according to State Society advisors. Physicians should talk to parents and legal guardians about their understanding of the information in the brochures, and should document the patient record that the information was distributed as required.

Dr. Moyers noted that the CDC brochure writers tried to make the information as readily understandable as possible, and the information on what to look for in shot reactions and certain risk factors may be useful to some parents. But he emphasized the importance of physician communication when administering vaccinations.

SUPPLEMENT

WHAT YOU NEED TO KNOW ABOUT THE ACELLULAR PERTUSSIS VACCINE

After the 1991 pamphlet *Diphtheria, Tetanus, and Pertussis: What You Need to Know* was prepared, a new pertussis vaccine became available for the fourth and fifth shots against diphtheria, tetanus, and pertussis. This sheet provides up-to-date information about the new vaccine. You should read this sheet after you have read the pamphlet.

WHAT IS THE NEW VACCINE?

DTP vaccine is usually given 5 times before a child reaches age 7 years. Until now, pertussis vaccine has been made from killed whole pertussis cells and mixed with diphtheria and tetanus vaccines to make the whole-cell DTP shot. The new acellular pertussis vaccine, DTaP, is made of only a few parts of the pertussis cell and is also combined with diphtheria and tetanus vaccines.

WHEN SHOULD IT BE USED?

The fourth and fifth shots of the DTP vaccine series are usually given to children 15-18 months old and 4-6 years old. The DTaP vaccine can be used only for the fourth and fifth shots. Testing is now in progress to show that DTaP is safe and effective for the first three doses. Until these studies are completed, this vaccine cannot be considered for use for the first three doses of the vaccine series. Whole-cell DTP vaccine should still always be used for the first three shots, and can still be used for the fourth and fifth DTP shots, although most experts will prefer to use DTaP vaccine. Compared with the DTP vaccine, after DTaP shots fewer children will be cranky or drowsy, have fever, or have soreness or swelling where the shot was given. Convulsions that occur after receiving DTP vaccine are usually caused by fever. With DTaP, there is less chance of fever, so convulsions probably occur less often. Experts do not know whether unusual, more serious problems which have been reported after DTP vaccine (mentioned in the pamphlet) happen less often after DTaP shots than after DTP shots.

WHEN SHOULD THE VACCINE NOT BE GIVEN?

If the health care provider determines that a whole-cell DTP should not be given, DTaP also should not be given. In that case, the child should usually get DT vaccine instead.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Medical Ethics and Maternal-Fetal Conflicts

James F. Drane, PhD

As ethical issues are raised by more and more aspects of medical practice, medical ethics becomes an ever more complex and confusing enterprise, presenting yet another physician dilemma. This article offers guidelines for individual physicians and hospital ethics committees in dealing with medical ethics and maternal-fetal conflicts.

"The impact of maternal behavior dangerous to the fetus is only beginning to be understood."

To most lay persons, the term "medical ethics" suggests that there is one right (ethical) answer to every question which experts in the field can provide. However, many different answers are proposed to all the important questions, and experts prefer to outline options rather than presume to give answers.

Despite an absence of unanimity about answers to particular problems, there are areas in modern medical ethics in which broad agreement exists. One can speak of a main-line, medical ethics agreement on death and dying issues, as opposed to a refractory and troublesome division on questions related to the beginning of life. The abortion controversy, for example, drags on in the courts, the legislature, the hospitals, and even in the streets. On one side of the dividing line, answers are based on women's freedom and privacy rights; the other side decides right and wrong based on the principles of sanctity and right to life.

Understanding the conflict

Abortion for some is a paradigm example of maternal-fetal conflict, and new medical technologies are expanding this conflict area. Even when pregnant women decide not to abort, but to carry a pregnancy to term, conflict possibilities between them and their fetuses emerge with every new technology. Sonograms, amniocentesis, chorion villus sampling, fetal therapies, and even fetal surgeries all raise the possibility of disagreement between what a woman might want for herself and what doctors believe to be best for her developing life. The fetus has become "a patient" as a result of technological advances, and this change of language and status sets up conflict possibilities with the maternal patient. Potential areas of conflict have also been expanded by changes in the lifestyles of many women. Most pregnant women go to great lengths to do everything beneficial for their babies. Not only do they abstain from legal and illegal drugs, but they even submit to painful procedures if the fetus will benefit. Recently, however, this traditional, moral characteristic of western society has weakened.

Thirty-seven thousand babies are born each year in the U.S to mothers who have used illegal drugs. In a Florida county (Pinellas), 3.4 percent of pregnant women used cocaine during pregnancy. Furthermore, alcohol use by mothers causes abnormalities and growth retardation in one of every 1,000 U.S. births, and fetal alcohol syndrome now is the leading cause of mental retardation. Also, 1.5 percent of New York City newborns are HIV positive, usually because their mothers engaged in high-risk behaviors.

The impact of maternal behavior dangerous to the fetus is only beginning to be understood. Sometimes a fetus survives the worst uterine environment with only limited damage. But as the number of severely handicapped babies mounts, the ethical issues associated with the beginning of life force themselves into the public and professional consciousness.

In American culture, the individual's right to make personal life choices is a basic one. Applied to the medical setting, this translates into a right to consent or refuse consent to treatment, and even a right to accept or to ignore medical advice. Once pregnant, however, the exercise of these typical American rights affects another human being: a child-to-be. Freely making one's own decisions, without interference from state or medical authorities, suddenly may mean endangering a fetus's life. The rights of pregnant women can quickly become pitted against the interests, if not the rights, of their fetuses.

Dr. Drane was Russell B. Roth professor of medical ethics at Edinboro University of Pennsylvania. He retired in December 1991.

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Resolving the conflict

The resolution of ethical dilemmas involving rights conflicts can be handled by the courts, but few believe that courts are the proper place for such problems. They can also be addressed by hospital ethics committees, which attempt to provide help while keeping the decision making within the doctor-patient relationship. In any case, either judges or hospital committees, including doctors, patients, and other medical professionals, will be addressing medical ethics with their pregnant patients—engaging in applied philosophy for which they may be well prepared, but not necessarily so. Professional medical associations are more and more frequently trying to provide ethical guidelines to prevent the worst ethical errors. And, of course, the American courts have developed their own corpus of literature on medical ethics.

"Can the fetus, too, be considered a patient toward whom the doctor has professional obligations?"

The court in *Roe v. Wade* left open the possibility of government exercising some degree of control over a pregnant woman's behavior. Since that case, however, the areas of potential maternal-fetal conflict have expanded, and older Supreme Court ethics are hardly adequate to address the many new situations in which a mother's behavior can be harmful to the life she carries. The medical ethics provided by law in effect are deficient, and other sources must be found to develop defensible ethical guidelines and policies.

The new conflict areas can seriously affect the doctor-patient relationship. Traditional medical codes were developed under different situations and either do not fit or provide little guidance for these new problems. According to tradition, the mother is the physician's patient and he owes her care, support, and confidentiality. But what do doctors do when medical care and direction are ignored? Can the fetus, too, be considered a patient toward whom the doctor has professional obligations? What is the extent of physician responsibility toward a fetus in situations involving harmful maternal behavior or a maternal medical decision which harms or creates risk for the fetus?

The American Academy of Pediatrics (AAP) Committee on Bioethics has provided general ethical directives for physicians facing these problems. In general, AAP advises respect for the American principle of individual autonomy, so that when a procedure beneficial to the fetus is opposed by the mother, the physician should honor the mother's refusal, even if the fetus will be harmed as a result.

Only in the following situations, according to AAP, may a physician consider challenging a woman's decision out of concern for benefit to her fetus: 1) when the fetus will suffer irrevocable harm without the treatment; 2) when the treatment is clearly indicated and likely to be effective; and 3) when the risk to the woman is low.[1] If all three conditions are present and the mother refuses, then the academy advises consultation with a hospital ethics committee. Turning to the courts is not recommended, except as a last resort; physicians are encouraged to handle medical ethical dilemmas within the clinical setting rather than turning clinical problems over to lawyers for solution.

The American College of Obstetricians and Gynecologists (ACOG) Committee on Ethics provides similar ethical directives for situations in which the mother's lifestyle or refusal of diagnostic/therapeutic procedures endangers her fetus. ACOG advocates education of the mother to follow doctor's orders but condemns the use of coercion because of its bad effect on the doctor-patient relationship. Like their pediatrician colleagues, when education doesn't work, ACOG suggests turning to a hospital ethics committee and avoiding the courts.

Developing ethical directives

Virtually everyone agrees that medical practice and hospital policy should not be dictated by the courts. The reason is clear: the culture of law is different from the culture of medicine, and physicians are much better off developing ethical directives that reflect the culture and ethics of medicine. Defensible medical ethics has to be adequate to clinical realities; court-dictated ethics rarely seem to be so. Besides, courts have provided very conflicting signals on cases of maternal-fetal conflict. Some courts have sentenced women to jail for behavior harmful to fetuses,[2] while others have overturned the use of legal force against maternal decisions thought to be threatening to fetal life.

Most famous among cases involving conflicts of interest between pregnant women and their fetuses is the Angela Carter case. Twenty-six-and-a-half weeks pregnant, she entered the hospital dying of metastatic cancer. She had to be so heavily sedated that her competency was severely compromised. Never was she able to carry on a reasoned discussion about her situation or that of her fetus. First she seemed to want to do what she could to improve the baby's chances, then

she seemed less clearly committed. Her mother had no such ambivalence—she did not want the baby.

Doctors, as often happens, were caught in the middle and decided to inform administrators about what was happening. The administrators, in turn, asked the court for a declaratory judgement. Judge Sullivan found it was "not clear what her intent was" and ordered a caesarean section performed. The baby lived only a few hours, and the mother died two days later. The ACLU entered at this point, and an appeal was initiated. In a sharply worded reversal of the trial court decision, the District of Columbia Court of Appeals ruled that "in virtually all cases the question of what is to be done is to be decided by the Patient—the pregnant woman—on behalf of herself and her fetus."[3] Subsequently, the family sued George Washington Medical Center for malpractice and civil rights violations.

In November 1990 the family and hospital settled out-of-court. The family accepted an undisclosed payment and an agreement to adopt a policy written by the hospital ethics committee which requires difficult decisions involving severely ill pregnant women and their fetuses to be made by each woman, her family, and her doctors, and not by the courts.

The George Washington Medical Center Ethics Committee policy is comprehensive and can serve as a guide for other hospitals. Its objective is to keep difficult decisions within the doctor-patient-family relationship. Ordinarily, consultation with the ethics committee is optional, but this policy requires that the ethics committee be consulted if a woman's preference is being overridden or before any court actions are initiated. The hospital policy reflects the need to balance the interests of the pregnant woman and the fetus. Process is important to guarantee that everyone involved understands the issues. If a maternal-fetal conflict cannot be resolved by committee involvement, either the patient may leave the hospital, or the hospital may withdraw from the case. According to the policy, a patient advocate will also be made available to help patients and their surrogates clarify complex issues and understand where help is available.

Consulting hospital ethics committees

The hospital ethics committee, of course, is always available for advice. In many court cases, hospital policies, and ethical statements by professional organizations, the hospital ethics committee is recommended as the first resource when conflict develops. But where does an ethics committee's expertise come from? What are the ethics of the hospital ethics committee, especially in disputed areas where the whole society, including the hospital community, is split?

A hospital ethics committee can provide help in conflict resolution, but only if it is well-trained and has worked to develop policy guidelines which reflect basic ethical principles and the mission statement of the hospital. As things now stand, one hospital ethics committee may provide advice and develop policies different from those of a neighboring institution.

Most everyone agrees that it is not good for medicine or society that life and death decisions depend upon where a patient happens to be treated. A hospital ethics committee then cannot simply apply either a pro-life or a pro-choice perspective. Solving problems created by a conflict between two interests or principles by opting for one over the other is sometimes inevitable and often-times appropriate at the personal level. But a hospital ethics committee, even in its case consultations, enters the area of policy; and policy involves a balancing of interests and principles, rather than simply choosing one over the other.

Different hospital committees may provide different advice on similar cases, but basic directives and committee methodology for coming to conclusions should be somewhat uniform. And every committee should try to balance legitimate interests in conflict situations. The life of the fetus and the freedom of the mother must both be taken into account, and the same is true of society's interests.

Balancing interests

Medical professionals have interests too, as do health care institutions, that also need balancing. Institutional policy will be influenced by a particular committee's make-up and the hospital mission/philosophy, but committees which stamp out ethical judgements from a single ethical perspective are likely to be a waste of time. Given the importance of balance, it is not advisable, even in Catholic institutions, to discount a woman's competent decision. In practice, ignoring women's interests makes very bad hospital policy, both ethically and legally. Reasonable and defensible policy must take the law into consideration without having ethics dictated by law or collapsed into law.

Pennsylvania's recently passed living will law (Senate Bill 3, now Act 24) pro-

motes and defends individual patient decision making, and requires respect for patient decisions to refuse life-sustaining treatments in terminal and comatose situations. But an exception is made in the case of a pregnant woman. Life-sustaining treatments, including nutrition and hydration, must be provided even against a pregnant woman's wishes, as expressed in a living will, unless the interventions will not contribute to a live birth or will cause harm and pain to the pregnant woman.

Even with such a law in place, an ethics committee has to carry out careful assessments of medical facts and patient interests including the fetal patient before providing advice and mediation. However, many hospitals have no committee trained to do this delicate work and have no guiding policies for conflict situations.

What is an individual physician practicing in a particular hospital to do when society is so split and the hospital has no policy? Prudential counsel would suggest the following:

- Discuss your own professional values or ethical beliefs with patients whom you think might be involved in behavior harmful to their fetuses.
- Be careful about overreacting when patients do not follow orders—it could signal a personal hang-up.
- Be very clear (e.g., draw pictures) about the effects of harmful behaviors on mother and fetus.
- Evaluate the patient's competence, and make a note of this in her file.
- Recognize that in this culture, patient autonomy—in situations involving options and/or conflicts of goods—is a firmly established value which must play a role in ethical decision making.

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2. Florida, Seminole County, Circuit Court, Criminal Division. *Florida v. Johnson* (Case no. E-89-890-CFA), July 13, 1989.

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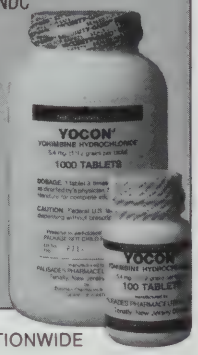
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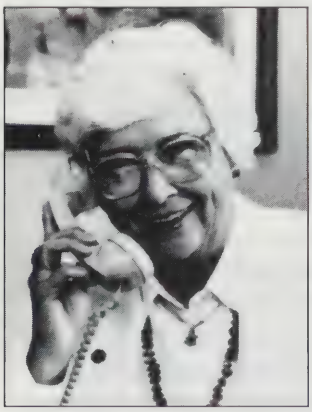
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Health Views from the House

Maria T. Montesano
Assistant Managing Editor



Representative Taylor is a Republican representing Pennsylvania's 156th District, Chester County. She is currently serving her eighth term in the House, and is minority chairman of the Health and Welfare Committee and a member of the Education Committee.

In this final of three conversations with members of Pennsylvania's legislature, Representative Elinor Z. Taylor talks about living wills, cost containment, health care access, and physician involvement in the political process.

This interview was conducted by Miss Montesano, in cooperation with the State Society's Department of Governmental Affairs Division of Legislative Affairs, Larry L. Light, director.

Question: *As Republican chairman of the House Health and Welfare Committee, you were involved in passage of the living will bill. What were your thoughts are on that bill?*

Representative Taylor: The bill was extremely important to senior citizens. They had been looking to the legislature for some assurance, some control during the death process, so that it could occur with dignity. Certainly, we in the House had fooled around with this for a long time, but I can't tell you how pleased I am to see that Pennsylvania does have a living will law.

I had an amendment added to the legislation for protection of the emergency medical community. Emergency medical personnel are committed to keeping a person alive. That's what their certification requires them to do. So, my portion of the bill says that if you have a living will, you should register it with the local emergency medical service. That way, if you require an ambulance in the last hours, the emergency personnel could be directed not to keep life going, but to honor the person's will.

Question: *But overall, you were pleased with the passage?*

Representative Taylor: Yes, I was.

Question: *I remember seeing you quoted in the newspaper as saying, "This has been held up for quite some time now—let's get it moving."*

Representative Taylor: Yes, I did. I said that, and if you recall, that was when there was a controversy between the Senate and the House. You can't let pride of authorship interfere with a piece of legislation that is this important.

Question: *Moving on, what is your response to this statement: Medical liability reform must be included in any health care cost containment reform.*

Representative Taylor: Well, if we are going to really look at health care costs, we are going to have to put in some liability reform. For example, we would have to limit awards for payments. Also, we would have to set a definition for malpractice and require the plaintiff to prove incompetence, malfesion, unethical behavior on the part of the doctor, rather than require the doctor to prove that what was done was correct.

It would appear to me that a portion of the "Greenwood proposal" [the Health Reform Act of 1992] is a limiting of physician liability by having patients consent in writing to major invasive procedures. When a patient agrees to a procedure, it would be presumed that the doctor is acting in accordance with accepted medical practice. And one step further, that medical treatment could not be conditioned on a patient who would refuse to sign an agreement. Those are two elements that have to be in any health care cost containment that we hope to have.

Question: *Speaking about cost containment, do you think the Certificate of Need (CON) process has been a viable means to control health care costs and expansion?*

Representative Taylor: I'm not sure what the answer to that is. In 1979 we passed Act 48, which is the Health Care Facilities Act. In 1980 I think health care costs—if we're going to tie CON to them—were about eight percent of the gross national product. That has risen today to 14 percent. And with some economic predictions that I saw, it will rise again—to 20 percent—by the year 2000...I don't know whether it's working or not. I think that the idea could work...that probably it hasn't worked because of some medical ramifications, not necessarily at the state level, but at the local level.

The health care industry itself has not shown noticeable restraint in capital ex-

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pansion and the management of services. For example, within a 30 mile radius of Harrisburg, we have six open-heart surgery units. If CON were working, possibly that wouldn't be true. But I will also say that CON cannot be solely responsible without the involvement of other issues, such as liability, if we are going to be successful in containing health care costs.

Question: *You introduced legislation for rural and family physician incentives. Could you talk a little about that?*

Representative Taylor: First of all, I introduced three bills. House Bill 729—introduced early in the session—would have set up an opportunity for health demonstration projects throughout the Commonwealth for primary care, inpatient health care, managed care, and a Medical Assistance buy-in. That bill was voted out of the Insurance Committee early in 1991, came to the floor of the House, and is now in Appropriations because it had a fiscal note of $4 million—$1 million for each project, the idea being, let's see how a pilot project might work.

I also introduced House Bill 530, which addressed the key barrier to rural health care: access. We simply don't have enough physicians, especially family physicians, to serve rural areas. The bill addressed the problem by trying to attract new physicians, awarding $100,000 to the medical school with the most innovative project to increase the number of family practitioners. Also, that bill would have provided loans to graduates of Pennsylvania's medical schools in the amount of $30,000 per year for each year of practice in a medically underserved area.

House Bill 530 was prepared as an amendment to House Bill 2594 [the Rural and Inner-City Health Care Bill] which was moved from the committee in April. House Bill 529, which was the companion bill, would have awarded scholarships to students in state medical schools. In exchange, students would serve one year in a rural area, and student loans would be repaid at the rate of $25,000 per year. Other bills are also being reviewed in committee.

Question: *What do you think is the most significant medical issue facing Pennsylvanians today?*

Representative Taylor: The number one problem is really two-fold: how do people access health care, and how do we pay for it?

We live in a society which considers itself civilized; yet, it doesn't take care of the weakest—the young and the elderly...Everybody would like to see health care spread so everyone has equal access, but health care is expensive. You only have to spend a few days in a hospital to know how expensive it is. I think to control it, we need to concentrate on a wellness program, to concentrate on immunization. It is less costly to work in those areas.

Also, if you were to ask me what else would guide my thinking in the area of health care cost containment, I would stress—and I am stressing to the [House Health and Welfare] committee—quality. You can have access, you can have affordability, and then you can have poor quality of medical care. I believe we have quality health care. The question is: How can we spread that quality so everyone can access and afford the program?

Question: *Speaking of the House Health and Welfare Committee, in what direction would you like to go in addressing those issues? You talked a little bit about wellness and immunization—what other ideas do you have?*

Representative Taylor: The committee doesn't have the privilege of beginning with a blank page and saying, "This is what the committee would like to offer in the field of health care costs." We can only look at what has been introduced: we can look at Tom Gannon's bill that creates affordable insurance for small business, and we looked at Bill DeWeese's bill that spoke to immunization.

The one thing that I haven't talked about is that the committee is looking very, very carefully at the issue of long-term care. While we have been bragging about our quality of health care in the United States, we have enabled people to live longer. And when people live longer, we get into [increased demands on] health care. The committee at present is looking at what is out there, and attempting to take the very best pieces of legislation and umbrella them into a package.

Question: *What is your view on how physicians can best get involved in the political process?*

Representative Taylor: While I don't think it's their primary responsibility, I suppose there is more doctors can do to be involved...To tell you the truth, I don't want my surgeon to be running around to political meetings. However, I do want him to have an avenue to express himself and to have input, and I want him to make sure he advises me about the problems that are out there.

FUNDS CUT IN BUDGET, GA PACKAGE OFFERED

The governor's proposed budget annually affects the medical community in a number of ways through financial activity in the state's medical and health care programs. With the 1992-93 budget, physicians' and medical students' eyes are focused on proposed cuts to medical school funding and the introduction of a general assistance (GA) basic benefits package.

Medical school funding

Available funding for non-state-related medical schools in 1991-92 totaled $135 million. For 1992-93 the governor's original budget cut all such funding and proposed a 3.5 percent cut for state-related universities for the remainder of 1991-92 and an additional 3.5 percent for 1992-93. Funding proposed for state-related schools for 1992-93 totals $531 million, with $23.6 million slated for medical programs.

Senate Republicans in early June passed an amended House budget bill which calls for a 1.2 percent increase in overall spending for the state, but $25 million less that the governor's original proposal. Included in the amended proposal is funding for all Pennsylvania medical schools.

For state-related schools, Senate Republicans agreed with the governor's 3.5 percent cut over what was approved for 1992-93. They did not, however, agree to the second proposed 3.5 percent cut in the 1991-92 fiscal year. For non-state-related schools, Senate Republicans approved funding at 90 percent of the 1991-92 budget plan. Movement on the issue by House Democrats had not occurred as of this printing.

GA basic benefits package

The Pennsylvania Medical Society, at the request of the Pennsylvania Department of Public Welfare (DPW), has commented on DPW's basic health care package for general assistance recipients. The package was proposed as part of the 1992-93 budget.

Intended to save more than $50 million for Pennsylvania, the package includes a range of covered services, such as hospital care, physician and clinic services, select medications, medical rehabilitation hospital care, day surgery, emergency care, drug and alcohol care, psychiatric care, laboratory and x-ray services, medical supplies, limited home health and hospice care, ambulatory services, and an HMO/HIO option.

Though implementation of the program was expected by July 1, in mid-June the department was still accepting comments and readjusting the plan, and could not pinpoint in what range actual savings would fall.

SUPPORT SOUGHT FOR LIABILITY REFORM BILL

A State Society proposal which would amend the state's medical malpractice act and addresses a series of underlying liability reform issues has been shared with potential sponsors in both the Senate and House. The Society maintains medical liability reform as a high priority.

Included in the proposal are both technical corrections and broader modifications of current law. Proposed amendments redefine informed consent, eliminate duplicative payments for the same injury, limit punitive damages in some instances, provide for installment or periodic payments for "future damage" awards of more than $200,000, and provide for arbitration agreements between patients and providers. Other provisions address statutes of limitations, "expert" witness qualifications, frivolous lawsuits, expansion of coverage, and risk management.

About 25 states already limit malpractice awards, and more than 30 have been trying to implement reforms since 1986, according to the Risk Management Foundation of the Harvard Medical Institutions, Inc. In Pennsylvania, two other related bills are in the works. The first, to be introduced by Representative Leo Trich (D-Washington), addresses parameters like those adopted in Maine. The second, Senate Bill 1728 introduced by Senator James Greenwood (R-Bucks), addresses health care cost containment and devotes a full section to medical liability reform. Several of the Society's provisions are addressed in Senator Greenwood's bill.

The Society is examining Senator Greenwood's and Representative's Trich's proposals, and following leads on other possible ties to proposed legislation. Additionally, the Society will continue to seek support for its proposal.

PHC4 POSTPONES REPORT RELEASE

Because of the many issues raised in comments to the Pennsylvania Health Care Cost Containment Council's (PHC4's) proposed research plan for the 1990 Hospital and Physician Report for Coronary Artery Bypass Graft Surgery, the release of the report will be delayed until fall. In the interim, the newly constituted PHC4 Technical Advisory Group and MediQual are reviewing the plan and comments. Recommendations are due back to PHC4 for review and action this month.

Current plans indicate that the report draft will be circulated to involved hospitals, physician groups, and physicians for review and comment in September. The release of the final report to the public may be in October. A number of significant concerns about the report—raised by the State Society's Task Force on Health Care Cost Containment and the Joint Committee on Health Care Data of the Society, the Pennsylvania Osteopathic Medicine Association, and the Hospital Association of Pennsylvania—remain unresolved at this time.

John A. Malcolm Jr., MD
Chairman, Task Force on Health Care Cost Containment
Pennsylvania Medical Society

NEW LAW EXPANDS HCFA 1500 USE BY INSURERS

A new law in effect June 2 expands the requirement that the HCFA 1500 form be used by commercial insurance companies. The legislation, formerly Senate Bill 969 and now known as Act 13, was written to ease physician "red tape."

The idea for the bill developed from a conversation between Joseph M. Clark, MD, a diagnostic radiologist in Lebanon, and state Senator David J. Brightbill (R-Lebanon); their cooperative efforts led to passage. Referring to Dr. Clark, Senator Brightbill said, "This shows that a single individual who recognizes a legitimate problem can have an impact."

The bill was originally introduced and passed by the Senate last year; it passed the House earlier this year.

PennDOT Publishes Amendments To Licensing Regulations

Susan M. Weber, Esq.

The Pennsylvania Department of Transportation (PennDOT) recently published amendments to regulations with respect to physical and mental criteria relating to the issuance of drivers' licenses. While the amendments do not alter the current mandate that physicians must report to PennDOT certain conditions which may interfere with a person's ability to drive, physicians should be familiar with the regulations and the effect that the listed conditions have on the likelihood that an individual will be able to obtain a drivers' license.

The regulatory standards are divided into three sections: 1) visual standards, 2) seizure disorder standards, and 3) other physical and mental standards. For ease of discussion, each section will be addressed separately in the following analysis.

Visual standards

The PennDOT regulations provide that a person with visual acuity of at least 20/40 may drive without corrective lenses, such as glasses or contact lenses. However, if acuity is less than 20/40 in one eye, the weaker eye must be corrected. *The amendments include a waiver from the corrective lenses requirement for those whose combined vision of more than 20/40 would not improve after correction of the weaker (less than 20/40) eye, as recommended by a licensed optometrist or opthalmologist.*

In general, a person with visual acuity of less than 20/40 must wear corrective lenses. At the far end of the spectrum, a person with visual acuity of less than 20/100 combined corrected acuity may not drive under any circumstances. This standard is an improvement, however, since previous regulations had prohibited driving by those with combined corrected visual acuity of less than 20/70.

Persons who have combined visual acuity of less than 20/40 may drive under certain circumstances. For example, if a person's acuity cannot be corrected to 20/40, he or she may drive in daylight hours providing that acuity is corrected to at least 20/60, or that a licensed optometrist or ophthalmologist using equipment to properly measure acuity states that combined corrected acuity is between 20/70 and 20/60.

PennDOT has adopted new criteria for those whose corrected combined vision falls between 20/100 and 20/70. PennDOT may issue a restricted license upon recommendation of a licensed optometrist or ophthalmologist who has proper diagnostic equipment, under certain circumstances.

The applicant must pass a complete vision examination on an annual basis. Upon application, the person must pass a driving exam. If the restricted license is granted, the person will be prohibited from driving on roads with speed limits greater than 45 miles per hour, will be limited to driving passenger vehicles which weigh less than 10,000 pounds, and may not drive motorcycles. Further, PennDOT may limit the person's driving to a specific geographic area.

In addition, PennDOT will conduct a review of the person's accident and driving violation history on an annual basis. PennDOT may revoke the restricted license if the person holding the license is "involved in an at-fault accident" or is convicted of two violations within a one-year period. The regulations do not specifically define what is meant by either an "at-fault accident," or two violations "within a one-year period." However, in order to provide for maximum flexibility, it is likely that PennDOT will utilize the concept of a "rolling" 12-month period for its determinations.

Other visual standards require a combined horizontal field of vision of 140 degrees or better, with allowances for "normal blind spots." Persons with vision in only one eye are required to use mirrors to provide a rear view of at least 200 feet. And finally, the use of "corrective lenses" for acuity purposes does not include the use of telescopic lenses.

Seizure disorder standards

Previously, people who experienced seizures could not drive until they had been seizure-free for one year; those between the ages of 16 and 18 who were applying for their first driver's license must have been seizure-free for two years. *The amendments require a seizure-free period of only six months and make no distinctions between teens and adults. Persons experiencing "auras only" have no driving restrictions under the amendments.* An "aura" is defined as "an epileptic seizure which does not cause a change in a person's ability to think clearly or interfere with the mechanical or sensory ability to operate a motor vehicle."

The six months' freedom from seizure requirement may be waived in certain circumstances, based upon recommendation from any licensed physician; previously, only a neurologist or neurosurgeon could make this recommendation. The requirement can be waived providing that seizures occur only nocturnally or immediately after awakening; this pattern must be determined over a period of the two preceding years with or without the benefit of medication.

A second situation in which the requirement could be waived involves a "specific prolonged aura accompanied by sufficient warning" established over the preceding two years, with or without the benefit of medication. While "aura" has been defined in the regulations, no time limitations are defined by the terms "prolonged" and "sufficient."

A third situation in which the requirement could be waived includes those instances in which a person had previously been seizure-free for six months but experienced seizures during prescribed medication dosage alterations or supervised withdrawal from medication. The waiver would be granted only upon return to dosages at which seizures had been controlled.

The seizure-free period could also be waived if a person had previously met the six-month requirement but subsequently experienced seizures as a result of a "nonrecurring transient illness, metabolic imbalance, or nonrecurring trauma."

A specific section of the regulations addresses the physician's

responsibility for reporting to PennDOT information about persons who have experienced even a single seizure while under the physician's care. PennDOT may, pursuant to the physician's report, require the person to undergo a medical examination.

Other physical/mental standards

The regulatory amendments make significant changes in that they disqualify certain people from driving by administrative fiat, which decision had previously been left to the physician's discretion. For example, the regulations prohibit driving by those with "unstable or brittle diabetes or hypoglycemia" unless they are free from syncopal episodes related to the condition for a six-month period. Similarly, the regulations prohibit driving by those with cerebrovascular insufficiency or cardiovascular disease which has resulted in syncope, loss of consciousness, dizziness, paralysis, or loss of certain visual fields within the previous six months. In addition, the driving ban extends to those who experience episodes of loss of consciousness with unknown etiology or types not listed unless they have been symptom-free for a period of one year.

The amendments provide for disqualification of drivers based on recommendation from the provider, defined as "a person authorized to diagnose or treat disorders or disabilities covered in this chapter, including but not limited to, licensed physicians, podiatrists, psychologists, and osteopathic physicians."

In the recommendation, the provider would advise PennDOT that the condition is "likely to impair the ability to control and safely perform motor functions" essential in driving. A laundry list accompanies the description of the recommendation, which includes physical disabilities or conditions such as loss or permanent impairment of a limb or part of a limb, neuromuscular diseases, orthopedic conditions, mental deficiency or mental retardation, or cerebrovascular insufficiency or cardiovascular disease which has, in the previous six months, caused symptoms which would impair driving abilities.

The list also includes mental or emotional disorders, or chronic alcohol abuse or use of drugs which results in inattentiveness, despondency, aggressiveness, or lack of concern for personal safety or the safety of others. The regulations prohibit reporting, however, with respect to any person participating in a drug or alcohol rehabilitation program which is federally funded. In addition, PennDOT may require special driver-competency examinations for those who have physical disabilities which inhibit motor control.

Physicians should bear in mind that the PennDOT reporting requirements are not new. They have only been refined by the Medical Advisory Board, which was established in 1976 when Pennsylvania became one of the few states to require physician reporting of driver qualifications. Only about six states currently require this type of physician reporting.

Editor's Note: Physicians from the Allegheny County Medical Society (ACMS) were instrumental in having the amendments formulated by the state's Medical Advisory Board.

Ms. Weber is assistant general counsel for the Pennsylvania Medical Society.

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Clarifying Concurrent Care

Dennis L. Olmstead

Pennsylvania Blue Shield's concurrent care policy for both the Medicare program and its private business is the source of much confusion and exasperation among physicians, especially with regard to medical-medical concurrent care. This article seeks to clarify the process for better understanding by physicians.

Proposed AMA Resolution

The Pennsylvania delegation to the AMA House of Delegates introduced a concurrent care resolution at the AMA's annual meeting in June. If adopted as proposed, the resolution would direct:

- that the AMA use all appropriate resources to accomplish uniformity among carriers in the application of concurrent care payment policies in the Medicare program,
- that the AMA use all appropriate resources to allow physicians to be identified by their specialty as reported to the carrier rather than an arbitrary definition established by a carrier for the purpose of concurrent care payment policy, and
- that a report of these activities be brought to the AMA House of Delegates in December 1992.

Concurrent care is defined by Pennsylvania Blue Shield (PBS) as care provided to an inpatient of a hospital or skilled nursing facility by more than one doctor simultaneously, during a specified period of time. Usually, concurrent care is provided when: 1) two or more separate conditions require the services of two or more doctors; or 2) the severity of a single condition requires the services of two or more doctors for proper patient management.

As a first step in Blue Shield's concurrent care review process, as with all claims processed by PBS, services must be deemed "medically necessary." To be considered such, the claim must demonstrate an active symptomatology or evidence of the disease, injury, or defect; and the need for services must be documented in the patient's records. If no identifiable relationship between the reported service and the diagnosis or symptoms is reported, payment will be denied.

Concurrent care claims must then be processed through concurrent care system edits, which screen by diagnosis code(s) and physician specialty. If a claim "fails" the edit process, e.g., the diagnosis code(s) used does not sufficiently support the need for the specialist or sub-specialist, the claim is rejected. Prepayment development for concurrent care, for the most part, does not exist. In other words, if the claim fails the system edits, PBS rejects it rather than sending a development letter to the provider. Under the Medicare program, however, prepayment development does occur on non-assigned claims where the denial is based upon medical necessity.

PBS policy states that the medical necessity for concurrent care is based on the patient's condition. It is therefore important that the claim form contain either the specific ICD-9 diagnosis code(s) that reflects the nature of the patient's condition, or the reason the physician is treating the patient. Additional documentation, such as hospital records, may be submitted with the claim to further explain the patient's condition and justify the medical necessity of the service. The records should also document the primary care physician's request for the consultant to see the patient and the seriousness of the patient's condition. The necessity of each physician's skills will be evaluated based on the ICD-9 code and/or this additional documentation.

Submission of medical records with the claim will delay initial claims processing and payment because the medical records must be reviewed. Ultimately though, if the claim fails the system edits, the submission of medical records with the initial claim filing would expedite payment, since records would eventually have to be sent to Blue Shield to justify the service under the postpayment review process.

Thus, the physician has a decision to make. If he or she believes the ICD-9 diagnosis code(s) stands on its own to justify the medical care rendered by specialty, the physician may not need to submit the records. If he or she does not believe that the ICD-9 code supports the concurrent medical care provided, the physician may need to send the medical records with the initial claim.

In addition to the diagnosis and/or medical records sent for the patient, PBS reviews physician specialty in determining medical necessity. Similar specialties simultaneously providing medical care may cause the physician's claim to be rejected. For example, PBS considers the following specialties the same as or comparable to "internal medicine" when evaluating the medical care provided to the patient: cardiology, endocrinology, family practice, general practice, preventive medicine, pulmonary disease, and

Mr. Olmstead is the State Society's director of medical economics.

rheumatology. Blue Shield non-Medicare business also considers pediatrics and pediatric cardiology as the same specialty for purposes of concurrent care.

The Health Care Financing Administration (HCFA) has stated that while it is not unusual for concurrent care to be performed by physicians in different specialities or sub-specialties, the need for such care would not be considered medically necessary in many cases. HCFA believes that these physicians generally possess the same skills and knowledge necessary to treat the patient. HCFA also acknowledges, however, that there are valid circumstances in which a patient may require the services of two "like" physicians, i.e., when one physician has limited his/her practice to some unusual aspect of a specialty.

Payment guidelines

PBS medical policy payment guidelines are established according to the type of concurrent care rendered. The guidelines for medical-medical concurrent care are:

- Under some circumstances, concurrent care services are *not* required on a daily basis for the entire hospitalization.
- The admitting doctor should be responsible for primary care and be paid for medical care, unless the patient is transferred to the consultant.
- Generally, PBS does *not* pay for the concurrent treatment of: 1) two or more separate conditions by physicians of the same specialty, 2) the same condition by physicians of the same speciality; or 3) the same condition by physicians *not* of the same specialty. In each case, Blue Shield's definition of "specialty" is assumed.

Advice for physicians

To avoid rejection of concurrent care claims and/or a request for additional documentation, physicians should:

- insure that the proper ICD-9 diagnosis code(s) specific to the degree of severity of the patient's condition being treated is used when billing;
- insure that PBS has on file the physician's correct specialty designation; and
- append a "22" unusual services modifier to the procedure code billed, and attach hospital records which justify the medical necessity of services being billed.

Typifying Conditions for Which Concurrent Care Services May Be Eligible

The following is a partial listing of conditions identified by Pennsylvania Blue Shield as typifying conditions for which concurrent care services may be eligible:

Blood and blood-forming organs; malignancies

Anemia (aplastic, Cooleys hemolytic, sickle cell, hypoplastic); hemophilia; Hodgkins disease; leukemia; lymphoma; multiple myeloma

Integumentary

Burns; scleroderma; erythema gangrenosum

Cardiovascular

Atrial fibrillation; cardiac arrest; cardiac arrhythmias; cardiac surgery; congestive heart failure; cor pulmonale; myocardial infarction; shock; hypertension, severe; thrombosis, acute

Gastrointestinal

Hepatitis; ulcer (gastric, duodenal, enteric); pancreatitis; cirrhosis; inflammatory enteritis, colitis, or enterocolitis

Genito-urinary

Acute renal insufficiency; chronic renal disease; urinary hemorrhage; eclampsia, pre-eclampsia; urinary tract infection with septicemia

Acute infectious diseases

Acquired Immune Deficiency Syndrome (AIDS); AIDS-Related Complex (ARC); infectious mononucleosis; tuberculosis, active; sarcoidosis; septicemia or viremia

Metobolism and endocrine system

Acute anaphylaxis; diabetes mellitus, uncontrolled and/or insulin dependent; adrenal failure; hyperparathyroidism; heat stroke

Musculoskeletal

Arthritis; myopathies; osteomyelitis; Paget's disease, complicated

Nervous

Drug intoxication; cerebral vascular accident; coma; meningitis; multiple sclerosis; Parkinson's disease; head injury; encephalitis

Respiratory

Abscess of lung; pneumonia; bronchial asthma (acute); cystic fibrosis; pulmonary edema; respiratory arrest; respiratory insufficiency and/or failure; chronic obstructive pulmonary lung disease

Miscellaneous injury and poisoning

Compressed air sickness; drowning; electric shock; poisoning (chemicals, drugs, heavy metals, toxic gases)

Psychiatric

Psychosis, acute

For a complete listing of conditions, contact the Society's Department of Medical Economics at 1-800-228-7823.

MEDICARE CONVERSION FACTOR SPLIT FOR 1993

The Department of Health and Human Services (HHS) in late May recommended a two-part Medicare physician payment schedule conversion factor update for 1993. HHS Secretary Louis W. Sullivan, MD, also presented the Medicare Volume Performance Standard (MVPS) for fiscal year 1993, as well as potential program directions for congressional and public consideration.

The two-part update will be applied on a service-specific basis as follows: for surgical services, the recommended update is 2.6 percent; and for non-surgical services, the recommended update is 0.3 percent. The recommendation is based on an update equal to the projected Medicare Economic Index (MEI): 2.2 percent, plus or minus the percentage points by which the MVPS was exceeded or was less than the actual rate of increase for surgical and nonsurgical services for the fiscal year 1991. MVPS figures recommended by HHS were 6 percent for surgical services and 7.9 percent for nonsurgical services.

Modifications being considered for 1994 include:

- a single MVPS and conversion factor update;
- acceleration of the payment schedule transition;
- a separate MVPS for primary care services;
- a restructuring of graduate medical education payment to favor primary care and to non-hospital-based, ambulatory residency training sites; and
- increased emphasis on primary care in Public Health Services programs.

The Americal Medical Association (AMA) has previously argued that multiple conversion factor updates are inconsistent with the resource based relative value scale (RBRVS) and should not have been recommended. Currently, the AMA is reviewing Dr. Sullivan's full report, and still believes that important elements of RBRVS require correction and refinement.

BLUE SHIELD, SOCIETY ANSWER RBRVS QUESTIONS

A number of general questions regarding Medicare coding, payment policies, audits, etc., were raised by physicians at the regional resource based relative value scale (RBRVS) seminars sponsored by the State Society. Questions were mailed directly to Medicare via special question forms handed out at the seminars.

What follows is a sampling of questions from those seminars and their corresponding answers, compiled by Pennsylvania Blue Shield Medicare representatives and amended *in italics* by the Society's Council on Medical Economics staff. The Society will publish additional questions and answers on Medicare payment reform in the future.

How do I bill for a hospital admission associated with an office visit on the same day?

When the patient is admitted to the hospital in the course of an encounter in the physician's office, all evaluation and management (E/M) services provided by that physician in conjunction with that admission are considered part of the initial hospital care when performed in the other site of service, as well as in the inpatient setting.

Services such as diagnostic tests, pathology studies, and radiologic studies—performed in any place of service—should be reimbursed in addition to the E/M services rendered that day.

If an evaluation (99201-99215, 99241-99273) involves an endoscopic procedure (31250-31375) to complete the evaluation, are both procedures or just one billed? If only one, which?

Separate payment will be made for an office visit (99201-99215) and an endoscopy on the same day if a separate, readily identifiable service was provided. If you are providing a service beyond recordkeeping, counseling, prescribing recovery therapy, etc., you may bill an office visit with modifier "25," in addition to the endoscopy.

The consultation codes, 99241-99273, may be billed when you have been asked by another physician to render your expert opinion of the patient's problem. As the consultant, you must prepare a written report back to the requesting physician. Therefore, a consultation and an endoscopy may also be performed on the same day.

By definition, a history and physical are recognized as separate and identifiable services. Therefore, a visit comprising a history and physical could be reimbursed in addition to the endoscopy using modifier "25" with the visit code. Additional documentation does not need to be submitted with modifier "25" billings.

Will Medicare pay for the administration of an injection on the same day as an office visit?

Payment for the administration of a therapeutic injection will *not* be made when the injection is performed in conjunction with an office visit on the same day. Payment will be made for the visit and the cost of the drug. The appropriate level of E/M service should be reported in addition to the appropriate code for the drug. The administration service is considered to be part of the office visit. Injection administration (procedure codes 90782-90784, 90788, and 90799) will be paid when billed independently, i.e., no E/M service is rendered on that day. In this case, one of the administration codes listed above should be billed in conjunction with the appropriate code for the drug.

Payment can be made for visits, the administration of the drug, and the cost of the drug for chemotherapy injections. Payment can also be made for the cost of the drug, the arthrocentesis injection, and a visit on the same day, if the visit was for a separate and identifiable service, such as a history and physical to determine that arthrocentesis was needed.

Can physicians now bill patients for telephone calls made to patients regarding their care or problem since the last office visit?

Although Current Procedural Technology (CPT) has codes for telephone calls, Medicare will not make separate payment for them. Medicare's policy is that telephone calls are part of the physician work in the visit or service, and the payment for the visit or service encompasses the payment for the telephone call.

How can electrocardiograms (EKGs) be billed when they are interpreted in the hospital by a physician who has not seen the patient?

The Omnibus Budget Reconciliation Act (OBRA) of 1990 precludes separate payment for the

interpretation of an EKG. Thus, by law, payment may not be made for the interpretation of an EKG that is ordered or performed in conjunction with a visit or consultation. Additional relative value units (RVUs) were added to the visit and consult codes to account for physician work in performing this service. The interpretation of this legislation by the Health Care Financing Administration (HCFA) does not recognize payment for the interpretation of an EKG by a physician who performed the interpretation but did not order the test.

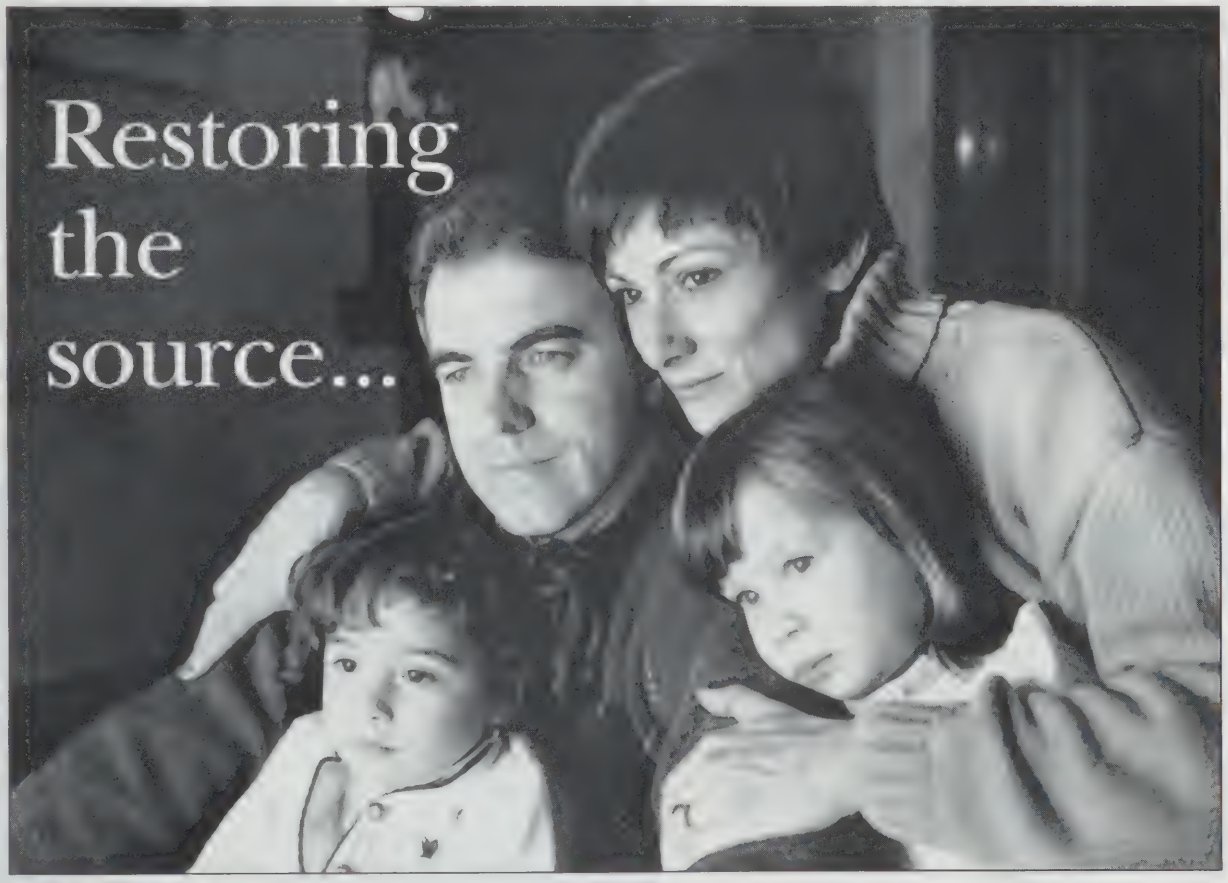
Payment is still permitted for the technical component billings of EKGs, as well as the professional interpretation of specialized EKGs, such as holter moniters.

If a 99291 is billed on a given day, can you also bill for additional time spent for Swan Ganz catheter insertion, arterial line insertion, or ventilator management?

Critical care (99291) reported on the same day as ventilatory assistance (94656-94662) will be combined and paid at the fee for 99291. The insertion of a swan ganz catheter or an arterial line will also be included in the critical care code. Critical care codes are intended to include all critical care services, performed during the critical care period, that require the constant attention of the physician.

Procedures which are not directly attendant to critical care management (e.g., setting of fractures, bladder tap) are not included in the critical care code and should be reported separately.

Other services which can be billed in addition to critical care include the suturing of lacerations, lumbar punctures, peritoneal lavage, and the reduction of joint dislocations.



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ACTIONS OF THE BOARD OF TRUSTEES, MAY 13, 1992

OFFICIAL HEALTH CARE REFORM POLICY ADOPTED

The Board amended and adopted a health care reform policy statement and goals recommended by the State Society's Committee on Long Range Assessment (see below).

The position statement sets forth broad criteria necessary for any meaningful reform movement, rather than advocating specific proposals. The statement has been designated as policy to be used to respond to media, to evaluate the merits of reform plans advocated by others, and to develop the Society's own health care reform proposal.

CERTIFICATE OF NEED POSITION STATED

The State Society's Board of Trustees, at its May meeting, adopted a position statement on Certificate of Need (CON) recommended by the Hospital Medical Staff Section (HMSS). Pennsylvania's CON program is scheduled to sunset December 31, 1992; however, a modified CON program is proposed in House Bill 1982.

Past Society policy supported a "free and competitive health care market" relative to CON. The HMSS recommendation adopted in May continues to support that position and advocates assurance of quality through appropriate licensure standards.

SOCIETY SEEKING CLAIMS DATA STANDARDS

At the recommendation of the Council on Medical Economics and the direction of its Board, the State Society will seek to have

PENNSYLVANIA MEDICAL SOCIETY HEALTH CARE REFORM POLICY

The goal of the physician is to prevent illness and treat injury or disease in the most skilled and professional manner. The Pennsylvania Medical Society believes physicians must always place the welfare of their patients first, ahead of personal interests.

Our nation has the expertise and technology to provide the finest quality health care in the world, and the strengths of our existing system should be preserved. However, the Pennsylvania Medical Society recognizes that reform is needed to address the imperfections of the health care system—including rising costs and the absence of health insurance coverage for millions of our citizens. Therefore, in the best interest of the public's health, physicians must be committed to reform and to playing an active role in the process.

Goals

Universal access: The Society believes all people should be able to obtain basic health services. To facilitate access to basic health care, financial resources must be made available. At the same time, geographic, social and cultural barriers, and other impediments to health care access must be overcome.

Quality: The Society is committed to the highest possible quality in health care services and supports ongoing efforts to improve health care techniques and technology. The current high standard of quality must be protected throughout the process of reform—cost containment should not sacrifice quality.

Cost containment: Escalating health care costs must be curbed through measures which target the causes. The Society believes health system reforms should reduce administrative burdens on physicians and other providers, attack inefficiencies in the delivery system, address overutilization, and eliminate excessive charges and cost shifting. Reforms should stress the cost savings inherent in prevention and early detection of disease. Most importantly, the health care consumer should be an active participant in the economic decisions affecting health care.

Practice parameters: The Society supports the proper development of practice parameters, which are guidelines to assist physicians in clinical decision making. They provide a means to improve quality and assure appropriate utilization of health care services.

Health insurance reform: The Society believes reforms of the existing health care insurance system are necessary to ensure the availability of basic health care coverage for all people. Shortcomings to be addressed include restrictive eligibility criteria, such as pre-existing condition exclusions; the demise of community rating, which drives up the cost of coverage; and the lack of portability—workers' inability to take their health care coverage with them when changing jobs.

Public health initiatives: Health system reform is only one component of what is necessary to achieve the major public health goals of our nation. The Society believes it is absolutely vital that efforts be increased to promote healthy lifestyles and positive changes in community attitudes. Physicians must foster a commitment within the community to improving public health education and resolving chronic economic and social problems which lead to violence, substance abuse, and other unhealthy lifestyles.

Tort reform: Billions of dollars are spent each year on "defensive medicine"—tests and procedures conducted to protect medical providers against potential lawsuits. The Society believes an efficient and fair medical liability system should be developed to reduce cost-shifting, help control health care cost inflation, and protect quality.

Basic freedoms: The Society believes that both patients and providers must be assured basic health care freedoms, limited only by the delivery systems they choose: the public must be assured of the right to select their physician and their hospital; physicians and other health care providers must be assured the autonomy to select the location of their practices and their method of reimbursement. Individuals should be free to purchase additional health care services and coverage with their own resources.

Prioritization: Health care services should be ranked, or prioritized, according to some agreed-upon criteria in order to assure the most efficient distribution of resources. This belief comes as recognition that society may be unable or unwilling to expend the resources necessary to provide every available health care service. The Society also believes that this process of prioritization should be achieved through consensus of health care consumers, payors, and providers, with the role of physicians being to provide medical information necessary for informed choices. Any subsequent restriction of resources allocated for medical services through rationing should be determined by society as a whole with full understanding of the consequences of the choices made.*

Medical research and education: The Society believes that medical education and research must be promoted and supported to assure continued improvement in quality and efficiency.

*** Definitions:**

Prioritization—A listing of services according to an agreed-upon set of criteria.

Rationing—Determining which services will be made available.

Pennsylvania's Medical Assistance (MA) program use the standard claims data elements used by Medicare.

Most health insurors, including Medicare, Blue Shield, and the majority of commercial carriers, use the HCFA 1500 claim form. However, Pennsylvania's MA program requires information specific only to the MA program. A unique claim form, the MA319, was developed in the early 1980s, with input from the State Society, to gather this data.

Because the MA319 includes nuances not present in the HCFA 1500, many claims are returned to providers due to incomplete or incorrect information. Returned claim forms are one of many "hassles" associated with participating in MA, according to members. A 22-page "crosswalk" was developed by MA to use in conjunction with the HCFA 1500 form, but its use is not practical, according to the Society.

BOARD ENDORSES MBNA CREDIT CARD PROGRAM

The Society's Board of Trustees, at the recommendation of the Council on Medical Practice, endorsed the MBNA America affinity credit card program to be offered as an added member benefit. The program offers one of the highest credit limits available in the country, access to 24-hour service, and a special business card for professional use.

Credit lines offered by MBNA range from $3,500 to $50,000. Other benefits include travel/accident insurance ranging from $300,000 to $1 million, and lost-luggage reimbursement up to $3,000. The card's annual fee will be waived in the first year of card ownership. In subsequent years, the annual fee will be waived when card charges exceed specified amounts.

All members will receive a credit card application in the mail by September. For additional information at that time, call the Society's Department of Practice Services at 1-800-228-7823.

JUDICIAL COUNCIL NOMINATIONS APPROVED

The Board approved four nominations for a one-year term on the Judicial Council to fill the vacancy created by the death of D. Ernest Witt, MD. Nominated are: Henry H. Fetterman, MD, Lehigh County; Donald E. Harrop, MD, Chester County; David L. Miller, MD, Clarion County; and alternate, Joseph N. Demko, MD, Lackawanna County. Dr. Harrop was appointed to the position until the election in October.

Also, the following two additional nominations for the Judicial Council were approved to fill the vacancy created by the expiration of the term of Kenneth L. Cooper, MD, Lycoming County, in October: Thomas J. Kardish, MD, Bucks County; and Charles A. Lauback Jr., MD, Montour County.

SOCIETY OPPOSING HOUSE BILL 1516

At the recommendation of the Interspecialty Section and by direction of the Board of Trustees, the State Society will oppose in its current form House Bill 1516, which amends the HMO Act and regulates health maintenance organization (HMO) functions with regard to drug and alcohol treatment.

The Society expressed concerns that the bill:

- does not allow HMOs to credential qualified physicians to treat drug and alcohol abuse patients,
- includes qualifying criteria to permit individuals certified in "any three-year program or equivalent life experience" to treat drug and alcohol abuse patients, and
- does not include a qualified psychiatrist on the proposed Grievance Committee.



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SOCIETY CO-SPONSORS ANIMAL RESEARCH WORKSHOP

The Pennsylvania Medical Society, along with the AMA and the Pennsylvania Society for Biomedical Research (PSBR), co-sponsored "Medical Progress—A Miracle at Risk," a one-day workshop in May addressing the importance of animals to medical research. More than 65 physicians, residents, medical students, basic science faculty, lab animal technicians, veterinarians, and researchers attended the workshop, held in Hershey.

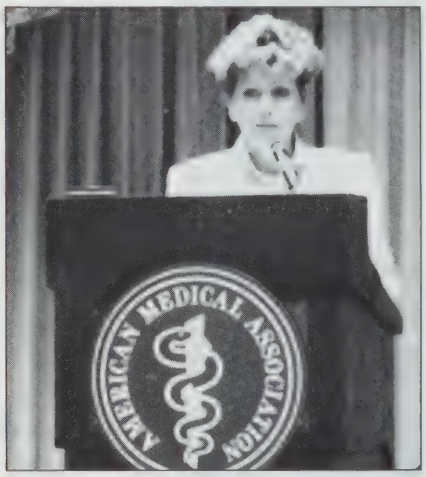
Introductory remarks were offered by Jerod M. Loeb, PhD, AMA assistant vice president of science and technology, and Robert N. Moyers, MD, State Society president. Karen A. Gorell, MSW, AMA project manager of the Group on Science and Technology, overviewed the goals of the workshop, which were to encourage practicing physicians to speak out on the issue, and to build grassroots support for the use of animals in research. Dr. Loeb then presented "The Price of Ignorance: Medical Progress vs. Animal Activism."

Several other national and local leaders also participated in the program. C. McCollister Evarts, MD, senior vice president for health affairs and dean of the College of Medicine at Penn State's Milton S. Hershey Medical Center, moderated a panel discussion entitled, "What Are We Up Against?" During the discussion, three panelists offered case studies: Richard Van Sluyters, OD, PhD, professor of optometry and chair of the Animal Care and Use Committee at the University of California, Berkeley, offered the targeted researcher perspective; Steve Carroll, executive director for incurably ill For Animal Research (iiFAR), offered the patient research advocate perspective; and Deborah S. Saline, director of public relations at the Hershey Medical Center, talked about animal activism and the Hershey facility.

In the afternoon, participants learned how to handle "tough questions" about the issue. Craig G. May, senior public information officer for the AMA, and Bruce Dan, senior editor of the *Journal of the American Medical Association* and anchor of "Medical Rounds" on American Medical Television, CNBC, discussed how to address emotionally charged topics and presented examples of situations where difficult questions are posed by biased or badgering individuals. Wiley R. McKellar, editorial writer for *The Patriot News*, Harrisburg, also provided a media perspective of animal-based research in Pennsylvania.

Another panel closed out the afternoon with "Personal Strategies—What Can I Do?" Moderated by Norman Wilkinson, PhD, PSBR executive director, the session included presentations by: Cooper Schenck, grassroots strategist at E. Bruce Harrison Company, Washington, D.C., on how to build an effective grassroots network; Craig B. Wisman, MD, cardiovascular and thoracic surgeon at the Hershey Medical Center, on educating patients about the role animals play in their medical care; and Ms. Gorell explaining the elements of a resource kit given to each participant to assist them in understanding the issues associated with the use of animals in medical research.

The AMA's resource kit contains materials for use in outreach activities, including such tools as a backgrounder on the animal "rights" movement, sample speeches with accompanying slides, a 10-minute videotape exploring the issues, sample written materials, and other resources to enable physicians to better inform patients. Also available to participants were a series of brochures from the conference's sponsoring organizations and the Pennsylvania Department of Health.



Karen A. Gorell, MSW, AMA project manager of the Group on Science and Technology, was one of several national and local speakers at "Medical Progress—A Miracle at Risk," a workshop, co-sponsored by the State Society, addressing the importance of animals to medical research.

FIRST RURAL HEALTH CONFERENCE HELD

The State Society participated in the first annual Pennsylvania Rural Health Conference, sponsored by the Pennsylvania Office of Rural Health (PORH) of The Pennsylvania State University. The conference, held in May in Harrisburg, brought together policymakers, health professionals, and educators to exchange information and ideas about the quality and delivery of rural health care in Pennsylvania.

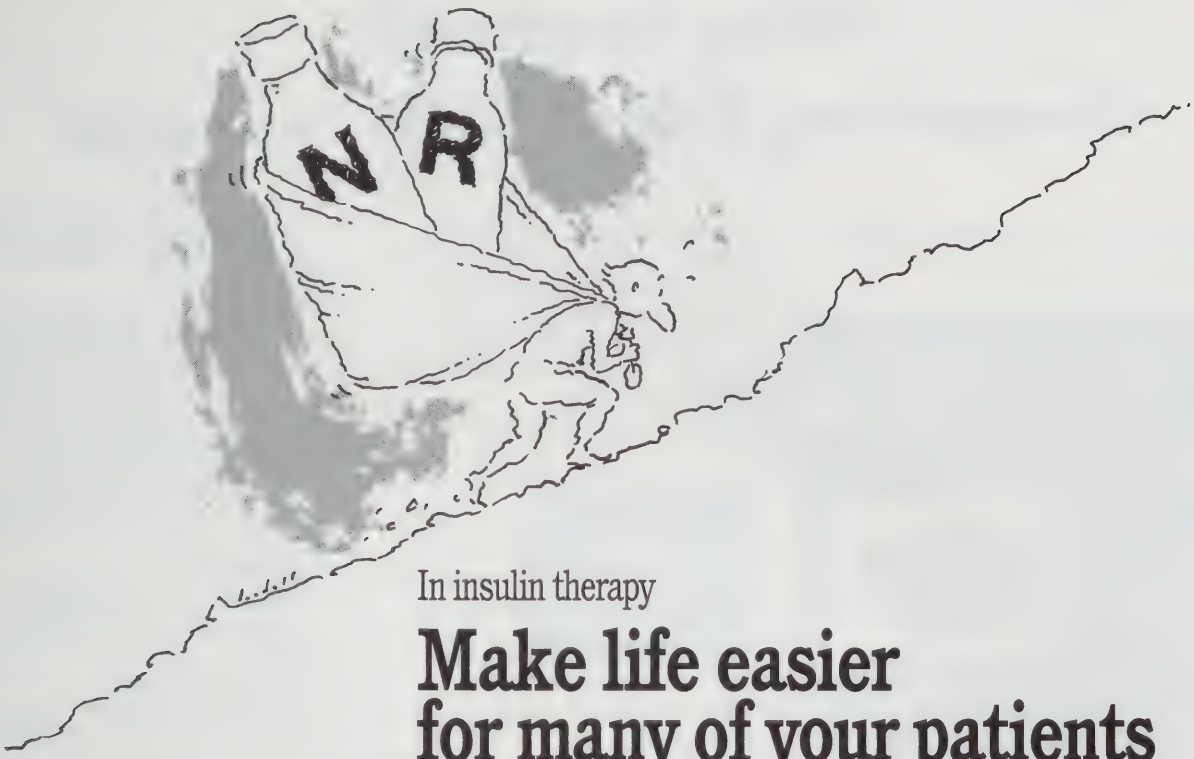
Acting Secretary of Health Allan Noonan, MD, MPH, presented the keynote address. He listed several rural health priorities, including:

- rebuilding the health professional shortage area (HPSA) designation process;
- coordinating with Pennsylvania's medical schools to use their graduates in rural areas within the state, rather than exporting them to other states;
- developing school-based health clinics;
- instituting "one-stop shopping" for health care needs;
- improving migrant health services;
- improving data collection;
- educating the rural population on health matters;
- strengthening the state's ability to assess the impact of toxic waste; and
- re-examining the Emergency Medical System.

The remainder of the conference focused on mental health and technology transfer, and several speakers outlined successful programs and projects at work in the rural areas of Pennsylvania and neighboring states.

The State Society supported this first annual conference through a financial contribution.

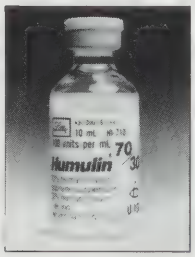
Robert J. Lilley, the Society's assistant director of educational and scientific affairs, contributed to this page.



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Office Overhead: Recognizing Hidden Costs

The Health Care Group

Physicians are accustomed to turning to traditional strategies to increase their gross income, such as maximizing reimbursement, increasing patient base, and reducing overhead. Of these, reducing overhead often seems to offer the least savings, as a few percentage points here and there would probably have little effect on a practice's bottom line.

The new Medicare fee schedule has changed that thinking. As reimbursement dollars shrink, two key management issues are moving to the forefront in every practice: cost containment and time efficiency. Regardless of practice size or mix of services, physicians should review expenses line-by-line. In the new reimbursement climate, it is essential to ask if each expense item *really* contributes to productivity—and those that do not should be trimmed.

A word of caution in undertaking this process: don't begin by firing or laying off employees unless the practice is *clearly* overstaffed. Personnel are the most valuable asset, albeit the biggest operating expense. Many practices react to economic pressures by eliminating some of these major expenses, when, in fact, such actions often result in decreased efficiency and in patient dissatisfaction, both of which will have a negative effect on income. Practices should review personnel costs, but should not focus entirely on payroll to save dollars.

The following is a list of cost-saving ideas that have proved helpful to many practices. Some represent big savings; others will have a smaller impact. Physicians should remember, however, that in today's environment cost efficiency is key. Given that, every dollar helps.

Personnel costs

- Review and rewrite job descriptions, assuring that higher-paid workers are not doing lower-paid work, such as filing, opening mail, and making bank runs.
- Limit the number of RNs on hand at any time, using them only for tasks requiring their training.
- Cross-train staff to fill in for temporary vacancies, vacations, and illnesses, thus avoiding temporary help and "floater" employees.
- Avoid overtime work by keeping office hours on time and staggering staff work schedules.
- Recruit, train, motivate, and supervise effectively to keep turnover—a very costly item—at a minimum.
- Develop pre-printed forms and standard form letters for insurance correspondence, patient recall, and records transfer to minimize secretarial time.
- Move payroll to an "outside" payroll service, thus reducing manager/bookkeeping/accounting time demands.
- In larger practices, develop salary grades to help monitor increases.
- Consider job-sharing positions that use part-time employees to staff full-time hours. Practices can attract good, experienced employees; gain flexibility during vacation time; and save on benefits, depending on the hours worked.
- "Flex-time" can also attract good candidates looking for non-traditional hours and can be a "benefit" to existing employees if used correctly.

Occupancy costs

- If more office space is needed, hire top-notch designers or architects with medical practice expertise to design for maximum efficiency.
- Schedule office hours so each exam room is used for as many sessions as possible, avoiding underutilized days, nights, and weekends.
- Sublet excess office space—especially for days, nights, and weekends—when not in use.
- Negotiate more demanding terms with the landlord, including repainting, carpet replacement, and limited rent escalation clauses.

Supplies

- Negotiate for a year's requirements of supply items at competitively bid prices, making sure to reopen the process each year.
- Avoid "panic ordering" at high prices by having a perpetual inventory system.
- Plan purchases by a yearly budget process, limiting purchases beyond the budgeted level.
- Purchase minor supplies (pens, pencils, paper products, etc.) through mail order houses, typically less expensive for generic items.
- Limit the number of people involved in the purchasing process.

Equipment

- Be critical as to whether maintenance/service contracts are needed for fairly simple items (e.g., a telephone system).
- Avoid wedding one equipment brand or distributor, retaining the ability to negotiate price and terms.
- Evaluate lease vs. purchase options.

Telephone

- Monitor phone bills, especially long distance, to see if all calls are justified.
- Consider alternative long-distance services, but keep reviewing the costs after switching—sometimes promised savings fail to appear.
- Have only the number of phone lines needed, possibly restricting some to incoming calls and dedicating others as "outgoing" lines.

Legal and accounting

- Move routine accounting functions in house, and onto a computer if possible, to reduce the need for the work of independent CPAs.
- Negotiate legal and accounting fees, obtaining advance agreement on fees and time deadlines for specific undertakings.
- Shop around for competent, lower-priced retirement plan administrative services.

Billing and collection

- Shop for computer supplies, pegboard systems, pre-printed fee slips, etc.: a regular vendor may make undue profits.
- Negotiate collection agency fees, possibly switching to a collection

letter service which doesn't charge on a percentage basis. Using two agencies often gives a practice a bargaining chip.

• In computerized practices, use electronic claims submission whenever possible in order to turn money around quickly. Investigate "linking" with the hospital admissions office for data retrieval, as well as lab and x-ray data.

Lab fees

• Be critical about using hospital labs. If their charges are higher, hospital lab use reduces the practice profit margin on self-pay and commercial insurance patients.

• Recognize that volume discounts may be available from outside labs.

Fringe benefits

• Drop key-man and buy-out life and disability insurance that should not be needed in properly structured inter-physician practice arrangements.

• Increase the deductible and co-pay elements of health insurance, and shop for changed health insurance (possibly even HMO coverage) every three years.

• Drop group term-life insurance. It's now an expensive way to provide some coverage for physician-owners.

• Eliminate staff fringe benefits which are not really important to employees. "Cafeteria" plans (which include dependent care plans and medical expense reimbursement plans) and "401(k)" retirement plans may produce savings.

Physician-level "perks"

• Have one person coordinate all ordering of professional books and journal subscriptions, avoiding duplication among group members.

• Choose practice-paid, vacation-oriented professional meetings carefully. Even if tax-deductible, they are still costly.

Miscellaneous items

• Computerize scheduling to better develop scheduling plans and increase efficiency.

• Computerize recall.

• Evaluate the tasks involved in seeing patients, and try to identify which tasks typically performed by physicians can be delegated to other staff members. Be sure physician time is not spent doing tasks someone else could do, such as making phone calls to check on test results.

These are just a few of the overhead costs that a physician may find hiding out in a practice. Reduce the costs, and let the savings boost the practice's income.

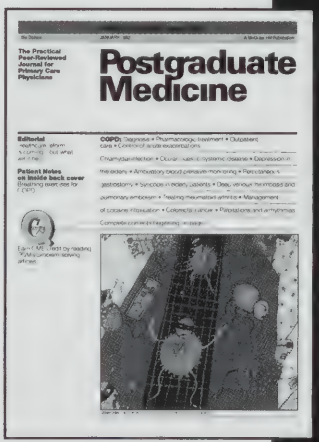
The contributing authors, Patricia M. Salmon and Edward L. Grab, are consultants with The Health Care Group, a medical practice management consulting firm based in Plymouth Meeting.

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Postgraduate Medicine

Possible Changes in Store for PRO Program

Donald E. Harrop, MD

Some drastic changes in the peer review organization (PRO) program have been proposed by the Health Care Financing Administration in recent months. Some of them are good, but, as we see them, some could cause problems for PROs, hospitals, and physicians.

"We are hoping for some compromises and more opportunity for negotiation before all these plans are finalized."

As this is being written, I know that much of what is now considered as the plan for the future of the peer review organization (PRO) program will change more than once before this gets published. Nevertheless, I will attempt to comment on how I view the prospects for the program in relation to the proposed changes.

Most government programs of this type have a life expectancy of about 10 years. There is no particular reason for this that I've ever heard of, but there are historical examples. For instance, the predecessors to the PROs were professional standards review organizations (PSROs). The PSROs were created by law in October 1972, received their first funding in mid-1974, and were replaced by the PROs in 1984. The PRO law was part of the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982. At that time, the changes from PSRO to PRO were really quite dramatic.

Single-state PROs replaced what were numerous PSROs around the country. There were 28 PSRO areas in California, 17 in New York, and 12 in Pennsylvania. The nature of the organizations also changed from strictly educational to somewhat punitive, and this is believed to have been caused by the Health Care Financing Administration's (HCFA's) fear that the newly enacted Prospective Payment System using DRGs would allow too much possibility for "gaming the system."

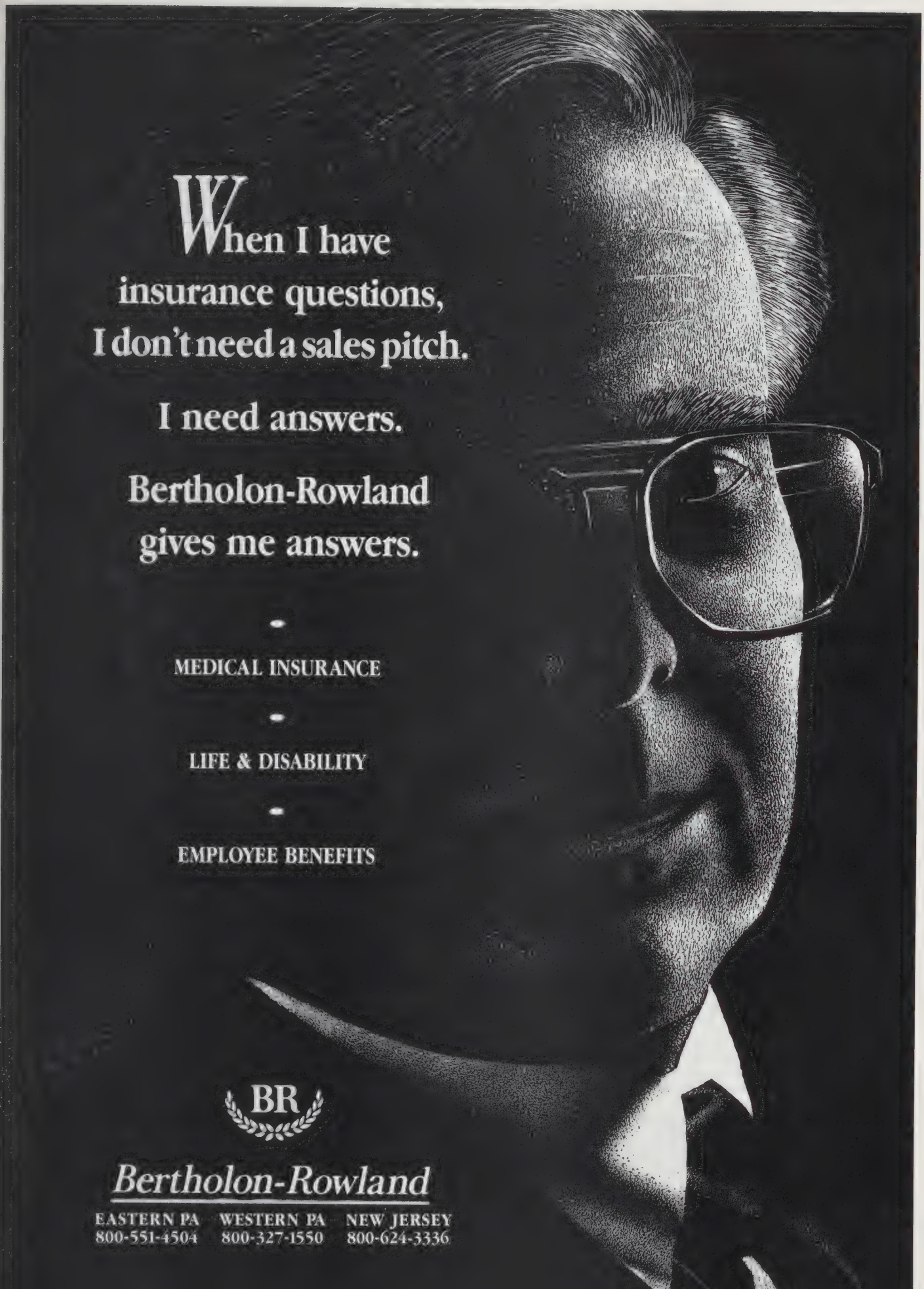
Here we are, 10 years after enactment of the PRO law, and HCFA is busy proposing new directions for what will be the fourth PRO Scope of Work. Their basic premises were fine. They named this new direction the Health Care Quality Improvement Initiative (HCQII) and announced that the thrust of the PRO program will become educational rather than punitive. The intent is to move away from individual case review to a broader review by analysis of patterns and outcomes of care. But, other proposed changes leave much to be desired. For example, last September's article in this column discussed the Uniform Clinical Data Set (UCDS).

This is the new data-collection and case-finding system which is comprised of a standard set of clinical data elements, based on algorithms that function to provide decisions on which cases should be referred to physicians for review. HCFA has proposed creation of five regional organizations called clinical data abstraction centers (CDAC) which would do all of the medical record abstraction using the UCDS. Those records requiring physician review would be sent back to the PRO for review.

The number of reasons why we think this system is poorly conceived will not fit in this article. However, here are just a few: it threatens patient, physician, and provider confidentiality since medical records will be mailed all over the country to CDACs which will not necessarily be PROs; because of the time it takes for UCDS abstraction of a record and the cost involved, the sample sizes for review have been drastically reduced which will allow egregious departures from acceptable care to go unnoticed; and the UCDS has not been tested sufficiently to allow for such a sudden and dramatic departure from traditional PRO review.

Although the PRO community is concerned about a number of such issues, they are not against change and do support the underlying direction HCFA is attempting to take. We are hoping for some compromises and more opportunity for negotiation before all these plans are finalized. It seems as though we have gone full circle since 1972 and are starting around again. We will try to keep you posted as new developments occur.

Dr. Harrop is president of the Keystone Peer Review Organization.


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Graduation Stats Up Five Percent From 1991

For the first time in several years, Pennsylvania's medical schools graduated a greater number of physicians than in prior years. The total number of men and women who received MD and DO degrees from the state's eight schools in 1992 is 1,225, a five percent increase from last year's figure of 1,166.

Estimated percentages of men versus women graduates have remained constant from last year, at 65 percent and 35 percent respectively. The percentage of women graduates varied by school, from a low of 24 percent at the University of Pittsburgh School of Medicine to a high of 49 percent at the Medical College of Pennsylvania.

A number of nationally known leaders spoke at the graduations, which were held between May 16 and June 5, and several honorary degrees and special honors were also presented.

Hahnemann University

Louis W. Sullivan, MD, secretary of the U.S. Department of Health and Human Services, and former Middle East hostage Joseph Cicippio received honorary degrees and spoke at Hahnemann's graduation on May 29 at the Academy of Music, Philadelphia. Dr. Sullivan received a doctorate of science and Cicippio received a doctorate of humane letters. Hahnemann confered the degree of doctor of medicine on 163 men and women.

Hershey Medical Center

AMA Executive Vice President James S. Todd, MD, presented the address to medical graduates of Penn State's College of Medicine at The Milton S. Hershey Medical Center. The ceremony was held on May 17 at Founder's Hall on the campus of the Milton Hershey School.

Among the college's 93 graduates were 37 women and 56 men. The number of graduates was up from 1991 by 35 percent; last year, 69 students graduated.

Jefferson Medical College

Michael N. Castle, governor of Delaware, received an honorary degree at Thomas Jefferson University's 168th commencement exercises on June 5 at the Academy of Music, Philadelphia.

Castle received the honorary doctor of letters degree for his efforts to broaden the delivery of health care services. Also honored with a doctor of science degree was Alfred G. Knudson Jr., MD, PhD, a renowned cancer researcher.

A total of 152 men and 59 women received MDs during the ceremony, an increase from last year's total of 209 graduates.

Medical College of Pennsylvania

The Medical College of Pennsylvania honored 111 medical gradutates at its 140th Commencement on May 16 at the Academy of Music, Philadelphia. Oliver Sacks, MD, the neurologist who wrote the book, *Awakenings*, received an honorary degree. Also honored were Rosemary Anne Stevens, MPH, PhD, dean of the College of Arts and Sciences and professor of history and sociology of science at the University of Pennsylvania, and Gail H. Foster, a longtime member of the college's National Board and president of the National Foundation for Women's Health.

Nancy Gary, MD, senior medical advisor to the administrator of the Health Care Financing Administration, was the graduation speaker. Dr. Gary spoke about quality care and health care costs.

Also this year, the college noted the twentieth anniversary of its first male graduates—four of them—in 1972. The class of 1992 had 57 male graduates.

Philadelphia College of Osteopathic Medicine

U.S. Senator Arlen Specter received an honorary doctor of laws degree and delivered the commencement address May 31 during the 101st graduation of the Philadelphia College of Osteopathic Medicine (PCOM), the nation's largest osteopathic medical college. Also honored as professor emeritus at the exercises—held at the Academy of Music—was Henry A. D'Alonzo, DO, MSc, FACOS, a distinguished surgeon and educator, and a 1951 PCOM graduate.

Of the 112 men and 84 women in the class of 1992, 75 percent were Pennsylvania residents, and 25 percent were from nine other states. The graduates represented 104 undergraduate colleges and universities, and 15 class members hold advanced degrees.

Temple University

During graduation ceremonies on May 21, Temple University School of Medicine graduated 171 physicians, a 7.5 percent increase from last year's total of 159. Ceremonies were held at the Academy of Music, Philadelphia. Kenneth R. Curdy, PhD, professor of microbiology and immunology at Temple, presented the commencement address.

MEDICAL SCHOOLS AND "THE OATH"

The original Oath of Hippocrates, set forth in 400 B.C., is no longer in use today in any of Pennsylvania's eight medical schools. Instead, the schools' medical graduates recite a "modern" version of the oath, if they recite one at all.

Common sense will tell you what might be offensive in the original version of the oath: references to "my own brothers" and "my own sons" may be considered sexist, and passages relating to not performing abortions bring up moralistic issues.

In order to allow for the changes in the medical community in the past 23 centuries, many of Pennsylvania's medical schools allow students to vote each year for the version of the oath they wish to recite. This year, seven of the eight graduating classes recited seven different versions of the "modern" oath, and one class opted not to recite the oath as part of its ceremony.

Among the "modern" versions used were the "Geneva" version written by the World Medical Association in 1948, the osteopathic oath, several versions written throughout the 1980s, and one version formulated by one of the graduating classes of 1992.

For a view of what the Oath of Hippocrates means to one Pennsylvania physician, see page 48.

Maria T. Montesano
Assistant Managing Editor

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AIR FORCE

University of Pennsylvania

The Irvine Auditorium on the campus of the University of Pennsylvania was the site of commencement exercises on May 17 for the school's medical graduating class. Of the 148 graduates, 100 were men and 48 were women.

Dr. Bernadine P. Healy, director of the National Institutes of Health, presented the graduation address entitled, "The Path is Made By Walking." In her comments, Dr. Healy discussed medicine as a healing art.

University of Pittsburgh

The University of Pittsburgh School of Medicine graduated 132 physicians on May 18. Among the graduates were 101 men and 31 women. Henry Bahnson, MD, of Pitt's Department of Surgery, spoke during the event, held at Carnegie Music Hall, Oakland.

"WOMEN IN MEDICINE" MONTH: SEPTEMBER

The Pennsylvania Medical Society is planning a series of activities in September as part of "Women in Medicine" month, designated by the American Medical Association and the American Hospital Association. Activities will focus on the status of women physicians and medical students, reflect how far women have come since entering the profession in the mid-1800s, and recognize women's accomplishments.

Highlighting the Society's efforts is an exhibit on the history of women in medicine, which includes a series of photographs from years gone by of women at work in the medical field. The exhibit will include informational publications for public interest and will travel around the state.

The Society is developing special recruitment materials and a fact sheet for physicians to copy and distribute in their offices. Also a proclamation will be requested from the governor. Watch for materials and information about September's activities in July and August. For additional information, call the Society's Department of Public Affairs at 1-800-228-7823.

Editor's note: PENNSYLVANIA MEDICINE is planning to include related articles in its September issue. The editors would like to hear from women physicians and students about what it is like to be female in the field of medicine. The magazine offers a number of departments in which to include comments. The copy deadline for the September issue is August 1; all submissions are welcomed.

County News

PHILADELPHIA COUNTY PRESIDENT ELECTED

Richard M. Gash, MD, has been elected to succeed Donald Kaye, MD, as president of the Philadelphia County Medical Society (PCMS) for a one-year term. Dr. Gash is medical director of the Police and Fire Medical Association of Philadelphia, clinical assistant professor of surgery at Temple University School of Medicine, and maintains a consultative practice in general surgery.



Dr. Gash

A graduate of the University of Pittsburgh School of Medicine, Dr. Gash served as a captain in the U.S. Army Medical Corps. Following his residency, he was an active attending in surgery at Albert Einstein Medical Center in Philadelphia, Rolling Hill Hospital in Elkins Park, and Lawndale Community Hospital in Philadelphia. He has been involved in organized medicine on a county and state level throughout his career, including as a delegate from Philadelphia County to the State Society since 1974. Dr. Gash is secretary of the Keystone Peer Review Organization, where he holds a number of other positions, and he serves on the board of the Florida Peer Review Organization.

Succeeding Dr. Gash as president elect is William S. Frankl, MD. The following have been elected to other PCMS offices: Thomas G. Garbuzda, MD, vice president; Ronald J. Carlucci, MD, secretary; and James L. Cristol, MD, treasurer.

LCMS OFFERS SECOND MINI-INTERNSHIP

Six community leaders participated in the second Lackawanna County Medical Society (LCMS) Mini-Internship Program, May 14-15, 1992. Among the participants was Senator Robert Mellow, who said, "The knowledge and insight gained from my experience is something that will benefit me in my legislative duties in dealing with health care issues."

Other community leaders involved in the program included representatives from labor and industry, welfare, community service, and banking, as well as an attorney. Each was invited to spend four half-day sessions with physicians at work. The program ended Friday evening with a dinner for the 22 participating physicians and interns to discuss their two-day experiences.

Senator Mellow said the experience gave him "a great realization as to the workings of our hospitals and more importantly the men and women who provide health care services to our people." He added, "The experience of the two days with the doctors I was assigned to gave me a greater appreciation for the length of day the doctors work. It also demonstrated the personal concern and relationship the physicians had with their patients."

As for the future of the program, Eric Blomain, MD, LCMS president, said it will be repeated in October, and a member from the American Association of Retired Persons (AARP) is already scheduled to participate. For additional information about the success and workings of the program, contact Pat Martin, LCMS executive director, at (717) 344-3616.

MERCER COUNTY PHYSICIANS ADDRESS STATE OFFICIALS

Nearly 30 Mercer County physicians met with state health care officials in May during a "Capitol for a Day" visit to Sharon. The program of visits, sponsored by Governor Robert P. Casey, has brought state officials to various cities throughout the state to discuss priorities and concerns with local leaders.

Allan Noonan, MD, Pennsylvania's secretary of health, and Cynthia Maleski, the state's acting insurance commissioner, heard the Mercer County physicians' views on such issues as increasing governmental hassles and regulations directed toward physicians, private insurers' plans, decreased Medicare reimbursement, the Auto Insurance

Reform Act, AIDS testing, and implementation of the Health Care Cost Containment Council's physician- and hospital-specific outcome data.

The physicians aired specific complaints about reimbursement of physicians' medical services for automobile accidents. State insurance department regional representatives said that the payment regulations were not promulgated until November 1, 1991, and payments were based on the conclusion of the Peer Review Organization's claim evaluations. Upon being instructed that their "trade groups" must present their positions to the insurance department, the physicians told Ms. Maleski that innumerable complaints had already been filed by individual physicians and the State Society.



Dr. Giordano

The Mercer County physicians discussed the onerous responsibilities placed on physicians by Pennsylvania's AIDS Confidentiality of HIV-Related Information Act, and the resulting decline in patient testing. Conflicts between Pennsylvania law and new federal regulations regarding bloodborne pathogens were discussed, specifically regarding regulations which allow physicians to test themselves and their personnel, as well as their patients.

Also aired were the physicians' views on the encumbrances associated with Medicaid and Medicare and the acceleration of limiting medical care resulting from the Health Care Practitioners' Medicare Fee Control Act and the federal Resource Based Relative Value Scale. The physicians noted that Pennsylvania is equated with Massachusetts as the most restrictive state in which to practice medicine.

Further meetings were planned with the secretary of health, and regional insurance department representatives have already contacted the physicians about the Auto Insurance Reform Act.

Joseph A. Giordano, MD
Sharon

SOCIETIES COMPUTERIZE SPEAKER PROGRAM

The Communications Committee of the Allegheny County Medical Society (ACMS), assisted by the State Society, has developed a Speakers Bureau Utilization computer program to organize and ease the county society's operations in providing speakers to the community upon request.

Linked to the State Society's membership files, the program automatically makes additions and corrections, eliminating file maintenance by the county. The program is also set up to: identify bureau participants by specialty, location, and speaking topics; track who has been contacted and their responses to county speaking requests; and quickly and easily compile reports of bureau activity on a monthly and yearly basis.

Other county societies interested in more "user" information about the program should call Lyn Riley, ACMS director of communications, at (412) 321-5030.

COALITION HONORS STATE BUSINESSES

Twenty-two Pennsylvania businesses were honored June 3 for their non-smoking policies in the workplace by officials of the Pennsylvania Department of Health and the Coalition for a Tobacco-Free Pennsylvania. The coalition is comprised of the State Society and a number of other state agencies and organizations.

Representatives of the businesses received a certificate from the Society and a plaque from the coalition distinguishing their company as a recipient of the "Pennsylvania Smoke-Free 2000 Business Award." To qualify, businesses must be smoke free, permitting no smoking indoors by anyone on the premises, and should have a related written policy in effect for at least six months. Items such as employee incentives for those who quit smoking, smoking-cessation programs, and other employee relations/communications activities are also considered.

Honorees in the medical field included: Capital Blue Cross, Harrisburg; McWilliams Pharmacy, Danville; Family Health Council, Pittsburgh; Mary Ellen Convalescent Home, Hellertown; and Merck & Co., Inc./Merck Manufacturing Division, Danville.

AMA News

SOCIETY RECEIVES DUES REBATE FROM AMA

The State Society has received $111,610.84 from the American Medical Association (AMA) for 1992 dues rebate. The total is $6,668.29 more than received in 1991.

In keeping with Society policy, 50 percent of the rebate will be distributed in the near future to county medical societies. Seventy-five percent of the CMS share is for AMA dues reported by January 15, twenty-five percent for AMA dues reported between January 16 and February 15, and five percent for AMA dues reported between February 16 and March 15.

SEMINARS TO ADDRESS LOSS PREVENTION

The Pennsylvania Medical Society Liability Insurance Company (PMSLIC) will present loss prevention seminars at six sites around the state this fall. The seminar program, "Curing and Caring," addresses how to deal with difficult patients and is designed for all physicians regardless of specialty.

"Curing and Caring" will focus on physician-patient relationships using both a lecture and workshop approach. Stephen E. Prather, MD, a practicing obstetrician and gynecologist from Utah, will lead the program.

Following the seminar, attendees should be able to communicate more effectively with difficult patients, describe optimal use of the consultation process, and develop a communication and teamwork plan to deal with angry and dissatisfied patients.

Two sessions—one in the morning and one in the afternoon—will be offered at each site. Locations and dates are:

September 23:
Sheraton East, Harrisburg
September 30:
Bel Aire Hotel, Erie
October 1:
Westin William Penn, Pittsburgh
October 20:
The Woodlands, WilkesBarre/ Scranton

November 4:
Warwick Hotel, Philadelphia
November 5:
The Holiday Inn, King of Prussia

PMSLIC is offering a 10 percent discount on 1993 premiums to all seminar participants. For PMSLIC-insured physicians, the discount will automatically be deducted from quarterly premium billings; other physicians who attend will receive a coupon for the same discount if they obtain their professional liability insurance from PMSLIC. Please note: a $300 minimum and $1,000 maximum apply to the discount program.

For additional information on credits and the program, or for registration information, call PMSLIC's Risk Management Department at 1-800-445-1212.

FACILITIES ENTER AFFILIATION AGREEMENT

Muhlenberg College, Lehigh Valley Hospital, and Hahnemann University School of Medicine have entered into a new affiliation agreement which establishes a program designed to link the undergraduate and medical school education programs of Muhlenberg premedical students.

Under terms of the agreement, qualified Muhlenberg College students may be admitted to the program when admitted to the college or during their first, second, or third years of study. Students admitted to the program, to begin this fall, are guaranteed admission to Hahnemann upon meeting required Scholastic Aptitude Test (SAT) scores and grade-point-average standards, and completing a pre-professional internship and their undergraduate degree requirements.

Students in the program may take part in research studies and other educational enrichment experiences at the participating institutions. Also as part of the agreement, Lehigh Valley Hospital will annually award a scholarship to a maximum of six students in the program.

DRUG MISUSE-PREVENTION MESSAGE DELIVERED

Senior volunteers are delivering a medicine misuse-prevention message to the nation's elderly under provisions of a newly announced partnership involving the National Council on Patient Information and Education (NCPIE) and ACTION, the federal domestic volunteer agency—both headquartered in Washington, DC. The project is funded by a $29,000 ACTION grant.

Citing studies that 243,000 senior citizens are hospitalized each year because of adverse reactions to prescriptions or over-the-counter drugs, the effort will dispense information kits to more than 750 local projects of the Retired Senior Volunteer Program (RSVP), federally administered by ACTION and made up of more than 427,000 volunteers age 60 and older.

The kits, produced by NCPIE and containing information about medicines and the uses of drugs, will urge seniors to deposit their prescriptions and over-the-counter drugs in brown bags, and seek advice from pharmacists and other medical professionals at community medicine review clinics or other events sponsored by participating RSVP projects. The project was developed in conjunction with Older American Month, observed in May.

QUARTERLY REPORTS FROM KEPRO OVERSEERS

The House of Delegates, through Resolution 86-44 (Amended), has mandated the Society to provide regular reports on Keystone Peer Review Organization (KePRO) findings.

The following report from the Ad Hoc Committee on KePRO Oversight covers the period January 1 through March 31, 1992. It shows the number of Medicare discharges, cases reviewed by KePRO physician reviewers, pending denials issued, final denials issued, and DRG changes made by KePRO.

KePRO Data for All Pennsylvania Hospitals 01/01/92 - 03/31/92

Medicare Discharges	*222,781
Cases Reviewed	39,774
Admission Denials	701
Administrative Denials	156
Total Denials	857
DRG Changes	1,301
PPS Hospitals Under IR	2
Generic Screen Failures	32,272
Pending Quality Problems	5,670
Confirmed Quality Problems	265

* Reflects total discharges received by KePRO for the reporting quarter.

TECHNOLOGY TO BOOST CLINICAL CAPABILITIES

A "new generation" of magnetic resonance imaging technology has been approved for purchase by officials at MRI OF YORK, a joint venture between York Hospital and Memorial Hospital.

Developed by GE Medical Systems, Milwaukee, Wisconsin, the new technology, called "multicoil array," will reduce imaging time when integrated with the computerized system in place at the imaging center.

Applications of the technology include male and female pelvic anatomy, the abdomen, and the spine. MRI OF YORK will be the only imaging facility in this region implementing the new technology, according to a representative of GE.

FYI: COST-OF-PRACTICE STATS OFFERED

Physician income continues to be a topic of great interest throughout the United States, but the reality of the price of maintaining a practice is often unseen by the general public. The following statistics, offered by AMA Communications Services, address a number of topics which may be of interest to physicians:

- According to the AMA's Center for Health Policy Research, physician net income after expenses comprises approximately 13 percent of overall health care expenditures.
- These days, physicians are working an average of 60 hours per week—100 more hours per year than they worked in the early 1980s.
- Average office expenses in 1983 amounted to $85,400; today a physician averages over $150,000 in office expenses.
- The price of medical supplies alone has doubled since 1982.
- The price of malpractice insurance has more than doubled since 1983. While the average obstetrician pays $34,000 per year for professional liability insurance, there are obstetricians in some high-cost states who pay upwards of $100,000 for such premiums.

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OBITUARIES

Robert E. Allen, *Mount Carmel*
Jefferson Medical College, 1927; age 93, died April 14, 1992. Dr. Allen was a general practitioner.•

Charles W. Delp, *Saint Clair*
Temple University School of Medicine, 1924; age 92, died April 8, 1992. Dr. Delp was a family practitioner.•

Max Harris, *Berwyn*
University of Vermont College of Medicine, 1940; age 76, died March 3, 1992. Dr. Harris was a pediatrician.•

John J. Kelly Jr., *Wynnewood*
Jefferson Medical College, 1954; age 63, died May 10, 1992. Dr. Kelly was a cardiologist.•

Henry G. McKeown, *Xenia, Ohio*
Hahnemann University School of Medicine, 1932; age 83, died March 28, 1992. Dr. McKeown was an internist.•

David S. Pollack, *Roaring Spring*
Hahnemann University School of Medicine, 1974; age 43, died April 22, 1992. Dr. Pollack was a general surgeon.•

Edward A. Troncelliti, *Media*
Jefferson Medical College, 1942; age 76, died April 13, 1992. Dr. Troncelliti was a pediatrician.•

James B. Gregg, *Chambersburg*
Kirksville College of Osteopathic Medicine, 1951; age 70, died April 1, 1992.

John M. Riva, *Philadelphia*
Tufts University School of Medicine, 1978; age 39, died March 22, 1992. Dr. Riva was a gynecological oncologist.

•Denotes membership in the Pennsylvania Medical Society at the time of death.

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TRIGEMINAL NEURALGIA AS A MANIFESTATION OF ACROMEGALY: A CASE REPORT

Larry N. Merkle, MD, FACP; Brian W. Little, MD, PhD; Robert A. Morrow, MD; Gerald Pytlewski, DO

OBJECTIVE: Trigeminal neuralgia is one of the most painful disorders known in medicine, and neurologists and neurosurgeons frequently make a strong effort in a search for identifiable and treatable causes of this facial pain syndrome. This paper was compiled as a case report of a patient with trigeminal neuralgia and acromegaly.

METHODS: A 66-year-old female was diagnosed as having acromegaly from a growth hormone secreting pituitary microadenoma with associated trigeminal neuralgia. Acromegaly was suspected because of suggestive clinical features and confirmed by endocrine testing. The patient eventually underwent transphenoidal pituitary exploration. Pituitary replacement therapy in the form of cortisone acetate 37.5 mg daily was required following surgery, as well as continuation of a previous physiological thyroid replacement.

RESULTS: The patient's post-operative course was relatively uneventful, and the surgery resulted in complete remission of her facial pain.

CONCLUSION: When usual causes have been excluded, acromegaly should be added to the list of potential treatable causes of refractory trigeminal neuralgia.

For additional information or a copy of the complete study, contact Larry N. Merkle, MD, FACP, at the Lehigh Valley Hospital Department of Medicine, (215) 402-8200.

CLINICAL USE OF AMBULATORY BLOOD PRESSURE RECORDING: VALUE IN PATIENT CARE

Alan P. Shapiro, MD; Daniel J. Glunk, MD; Bruce Barnhill, BS

OBJECTIVE: Variability of blood pressure determinations has long been recognized and results in considerable difficulty in evaluation of hypertensive patients. This study was conducted to evaluate the problems and value of routine clinical use of ambulatory indirect recorders in an outpatient setting in a hypertension practice.

METHODS: Using the Spacelabs 90202 monitor, 200 ambulatory blood pressure recordings (ABPRs) were obtained in 179 patients over a period of 25 months; 21 of the 200 determinations were duplicates in the same patients after a change in therapy. Data were fed into a computer programmed by Spacelabs software to compute averages.

RESULTS: Of the 200 determinations attempted, successful records were obtained in 197 (98 percent). Blood pressure and heart rate outcomes were compared in regard to various means, and several calculations were made from the computed averages.

CONCLUSION: Several insights were gained from use of APBR in the clinical care of hypertensive patients. The current "state-of-the-art" instrumentation is reliable, accurate, reasonably trouble-free, and acceptable to patients. It provides a day-long measure of blood pressure which possibly has prognostic and diagnostic implications, may provide a prediction of the course of the patient, and offers guidance to the understanding and adjustment of pharmacologic therapy.

For additional information or a copy of the complete study, contact Alvin P. Shapiro, MD, at the Shadyside Hospital Department of Medicine, (412) 623-2465.

HEMODYNAMIC PATTERNS ASSOCIATED WITH INFARCTED BOWEL

Mark Gannon, MD; Robert Weaver, AS; Matthew Indeck, MD; J. Robert Burns, MD; Sheldon Brotman, MD; Joseph L. Smith, MD

OBJECTIVE: Bowel infarction remains a diagnostic dilemma and therefore leads to increased mortality and morbidity. This study was conducted to review a series of intensive care unit patients with infarcted bowel in an attempt to characterize their hemodynamic profiles.

METHODS: Between December 1984 and May 1987, hemodynamic data for 27 patients with a diagnosis of ischemia or infarcted bowel, confirmed by either surgical pathology specimen or autopsy, were reviewed. A thermodilution pulmonary artery catheter was used to monitor pressures and oxygenation, and various data were then calculated using standard formulas.

RESULTS: Data from 16 patients were excluded because of infection, myocardial infarction, or ischemia, and/or insufficient data. The remaining 11 patients demonstrated hemodynamic profiles with sharply defined high and low functional patterns similar to those described for septic shock.

CONCLUSION: The lowest functional group had the highest mortality rate. This observation is consistent with human septic shock experience and animal models of mesenteric ischemia. This might suggest that translocation of bacteria or their products across the injured bowel wall may be the most likely reason for the similarity of findings.

For additional information or a complete copy of the study, contact Joseph L. Smith, MD, at the Geisinger Medical Center Department of Critical Care Medicine, (717) 271-6211.

The editors of PENNSYLVANIA MEDICINE encourage submission of scientific articles for publication consideration; however, abstracts of those articles not published in full are printed as a reference for readers. Please send submissions to: Medical Editor, PENNSYLVANIA MEDICINE, 777 East Park Drive, P.O. Box 8820, Harrisburg, PA 17105-8820. Full scientific articles are published at the discretion of the medical editor as consistent with the editorial schedule and are subject to revision.

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Robert L. Lasher, MD, a surgeon from Erie and the State Society's Eighth District Trustee, spoke in late May before the Republican Policy Committee Task Force on Health Insurance. Dr. Lasher presented the Society's comments on House Bill 2294, a small-business health insurance reform proposal.

Lee H. McCormick, MD, Pittsburgh family practitioner and chairman of the State Society's Task Force on Drug Abuse, has been appointed to the American Medical Association (AMA) Advisory Committee on Child Abuse.

Abram M. Hostetter, MD, Hershey, was honored in May by the Mental Health Association in Cumberland, Dauphin, and Perry counties for his many accomplishments in the field of psychiatry.



Dr. Hostetter

Rocio Nell, MD, has been appointed executive director of the Montgomery County Emergency Service, Norristown.

Rex Newton, MD, emeritus chief of the Department of Physical Medicine and Rehabilitation at Harmarville Rehabilitation Center, Indiana Township, was honored by the Pittsburgh Physiatric Society and the Harmarville facility for his teaching and lifelong contribution to the field of physical medicine and rehabiliation.

Gilbert A. Friday Jr., MD, professor of pediatrics at the University of Pittsburgh School of Medicine, has been elected chairman of the board of Pennsylvania Blue Shield.

Norman M. Krause, MD, specialist in orthopedic surgery and sports medicine, was elected medical staff president at the Greater Pittsburgh Rehab Hospital.

Two faculty physicians at the University of Pennsylvania Medical Center—**Robert Austrian, MD,** John Herr Musser professor and chairman emeritus of research medicine, and **Clyde Barker, MD,** John Rhea Barton professor of surgery, Donald Guthrie professor of surgery, director of surgical research, and chairman of surgery—were elected into the Institute of Medicine of the National Academy of Sciences.

Marvin Steinberg, MD, director of the Joint Reconstruction Center at the Hospital of the University of Pennsylvania and professor of orthopedic surgery at the University of Pennsylvania Medical School, moderated "Avascular Necrosis of the Hip" at the Combined Meeting of the American Orthopedic Association and the English Speaking World in Toronto, Canada, in June.

Loren H. Crabtree, MD, vice president of clinical affairs of the Westmeade Center, Wyndmoor, and **Robert Garfield, MD,** medical director of the center, were interviewed during a live taping of a local radio program, "Family Matters." Examining the issues surrounding stigma and alternatives to traditional psychiatric care was the topic of the program, and Drs. Crabtree and Garfield answered questions about the benefits of the alternatives to psychiatric hospitalization.

John V. White, MD, associate professor of surgery and director of surgical research, Temple University Hospital, was awarded the 1992 Dr. Samuel D. Gross Prize by the Philadelphia Academy of Surgery for his work on the cause of abdominal aortic aneurysms.

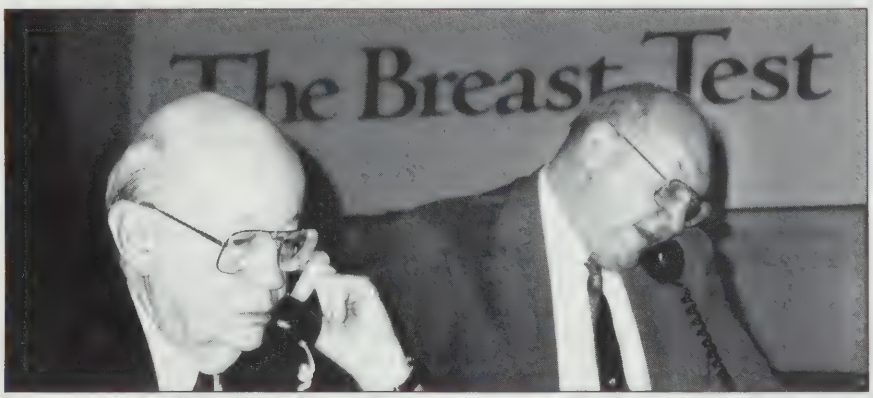


Dr. White

Stephen S. Silberstein, MD, FACP, chief of neurology and co-director of the Comprehensive Headache Center at the Germantown Hospital and Medical Center in Philadelphia, recently edited and authored a special headache supplement to *Neurology*, the official journal of the American Academy of Neurology. The supplement was entitled, "Intractable Headache: Inpatient and Outpatient Treatment Strategies." Also, **Elliot A. Schulman, MD,** co-director of the center, served as a contributing author to the supplement.

Judith L. Swain, MD, Herbert C. Rorer professor of medical services and professor of human genetics at the University of Pennsylvania School of Medicine in Philadelphia, and chief of the Cardiovascular Division of the Hospital of the University of Pennsylvania, will serve as principal investigator for a grant from Bristol-Myers Squibb to support breakthrough research on how the heart muscle develops.

Ronald B. Herberman, MD, director of the Pittsburgh Cancer Institute, received the Institute for Advanced Studies in Immunology and Aging 1992 Lifetime Science Award in recognition of his "insightful" work in the field.



State Society President Elect Donald G. Ferguson, MD (left), and Allegheny County Medical Society Past President Richard E. Deitrick, MD (right), were among 29 physician volunteers who answered viewers' questions on breast cancer detection and treatment during *The Breast Test*, a community outreach project airing on WQED-TV in Pittsburgh.

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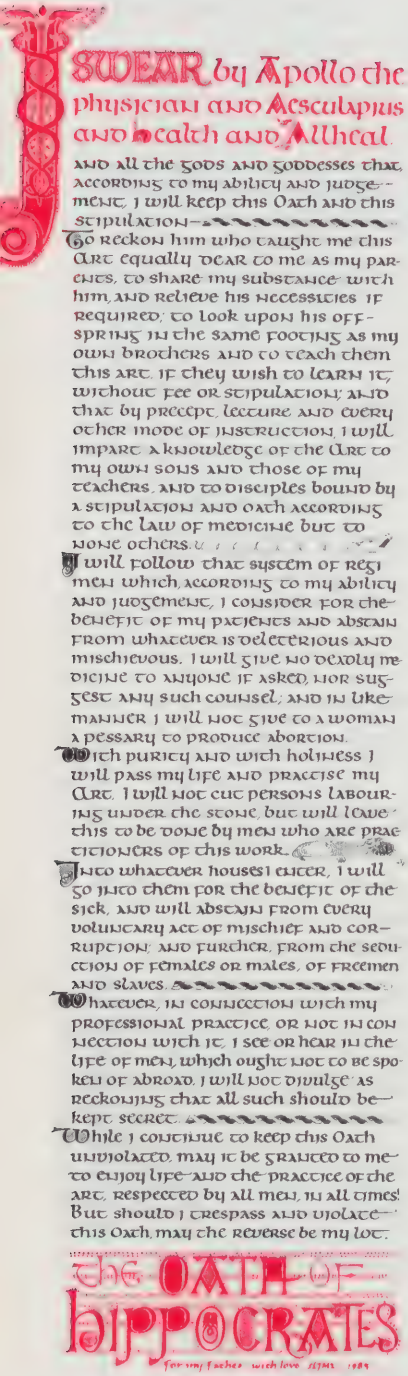
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A Refreshing View: The Oath of Hippocrates

Leslie E. Morris, MD



I was first exposed to the Oath of Hippocrates when I was a callow medical student in Trinity College, Dublin, in 1934. The oath was tastefully hung in the vestibule of the School of Anatomy. On the first reading, I thought the oath was pompous. Next year when I began to see patients, I read the document again. This time I was transformed by the magic of its message and read the oath several times each year.

When I graduated in 1939, there was no ceremonial reading of the oath. This did not bother me at all—I had the Oath of Hippocrates in my heart forever. Now, thanks to the generosity of my lovely daughter Sarah, I have a beautiful Hippocratic Oath [at left] hanging in my consulting room.

Hippocrates (460-377 B.C.) was the father of modern medicine. His principles of medical science were laid down 400 years before the birth of Christ, yet they formed the basis for the medical theory developed in the 1800s. The oath named for him gave the medical profession a sense of duty to mankind which it never lost—graduating medical students still take the oath.[1]

What is so amazing to me is the comprehensive content of this oath written 2,400 years ago.

It starts off: *According to my ability and judgment, I will keep this oath and stipulation—to reckon him who taught me this Art equally dear to me as my parents; to share my substance with him, and to relieve his necessities if required.*

I will impart a knowledge of the Art to my sons and those of my teachers. Little did he know that 24 centuries later the daughters would also acquire the art and would become outstanding physicians and surgeons.

I will follow that system of regimen which according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous.

I will not give to a woman a pessary to produce an abortion. I would hazard a guess that in ancient times, abortion had a mortality of 50 to 60 percent, at least. This may be the reason that Hippocrates avoided the procedure. I wonder, if he was confronted with a 14-year-old girl, pregnant from rape, whether he would deny her an abortion.

I will not cut persons laboring under the stone but will leave this to men who are practitioners of this work. Obviously he is warning students not to practice surgery without adequate training. Hippocrates also practiced surgery. He reduced dislocations of joints and set fractures; he bored holes in the skull to relieve pressure caused by brain tumors and other disorders.[2]

In whatever house I enter, I will go into them for the sick and will abstain from every voluntary act of mischief and corruption; and further from the seduction of females or males, of freemen and slaves.

Whatever I see or hear in the life of men which ought not to be spoken of abroad, I will not divulge as reckoning that all such should be kept secret.

This great document ends with a warning: *While I continue to keep the Oath unviolated may it be granted me to enjoy life and the practice of the Art, and respected by all men in all times!*

But should I trespass and violate this Oath, may the reverse be my lot!

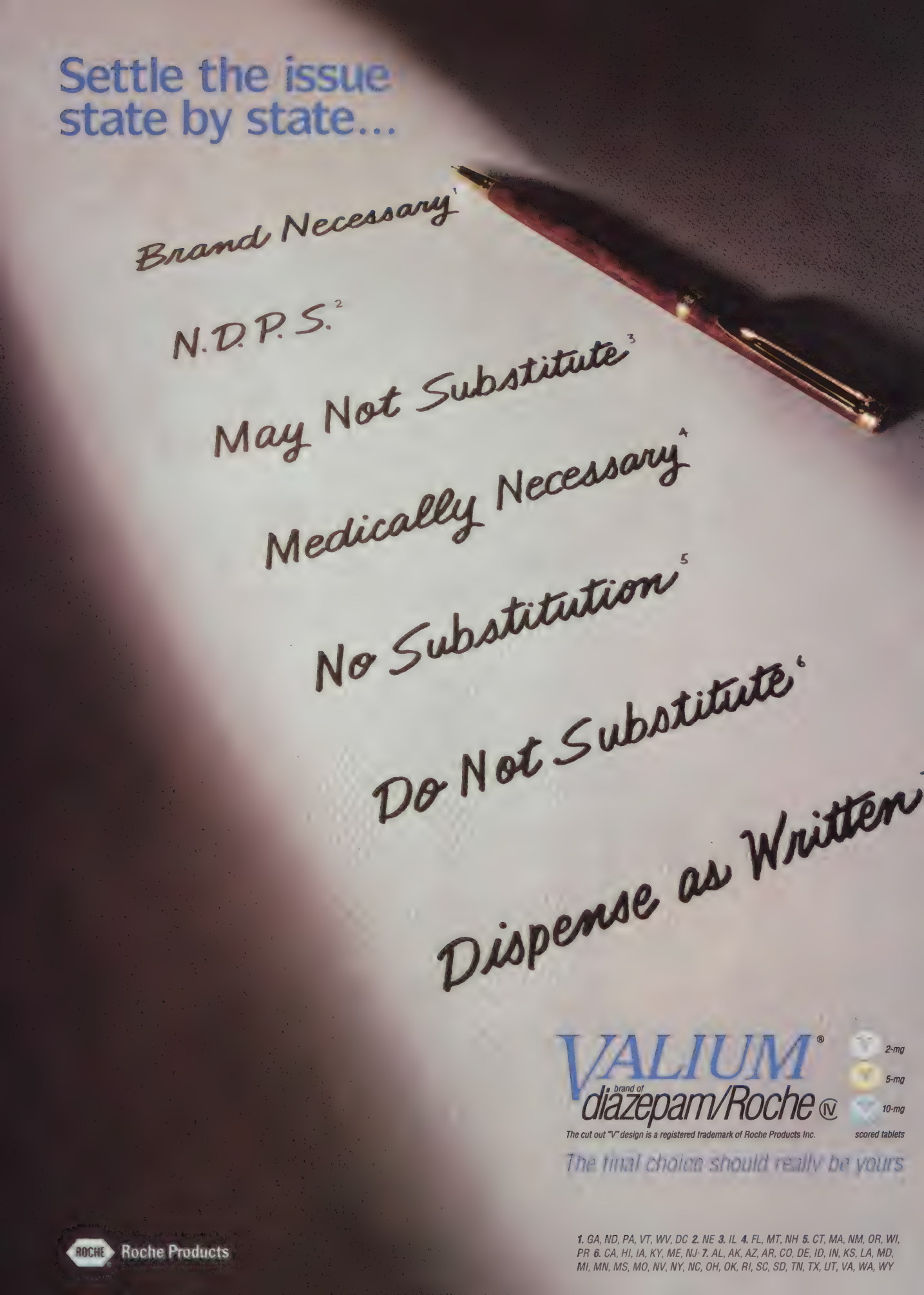
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1. *World Book Encyclopedia*. 8:266, 1960.
2. *World Book Encyclopedia*. 8:227, 1960.

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Leslie E. Morris, MD, is clinical associate professor of medicine at the University of Pittsburgh School of Medicine. He was chief of the Peripheral Vascular Clinic, Montefiore Hospital, for 16 years (1966-1982).

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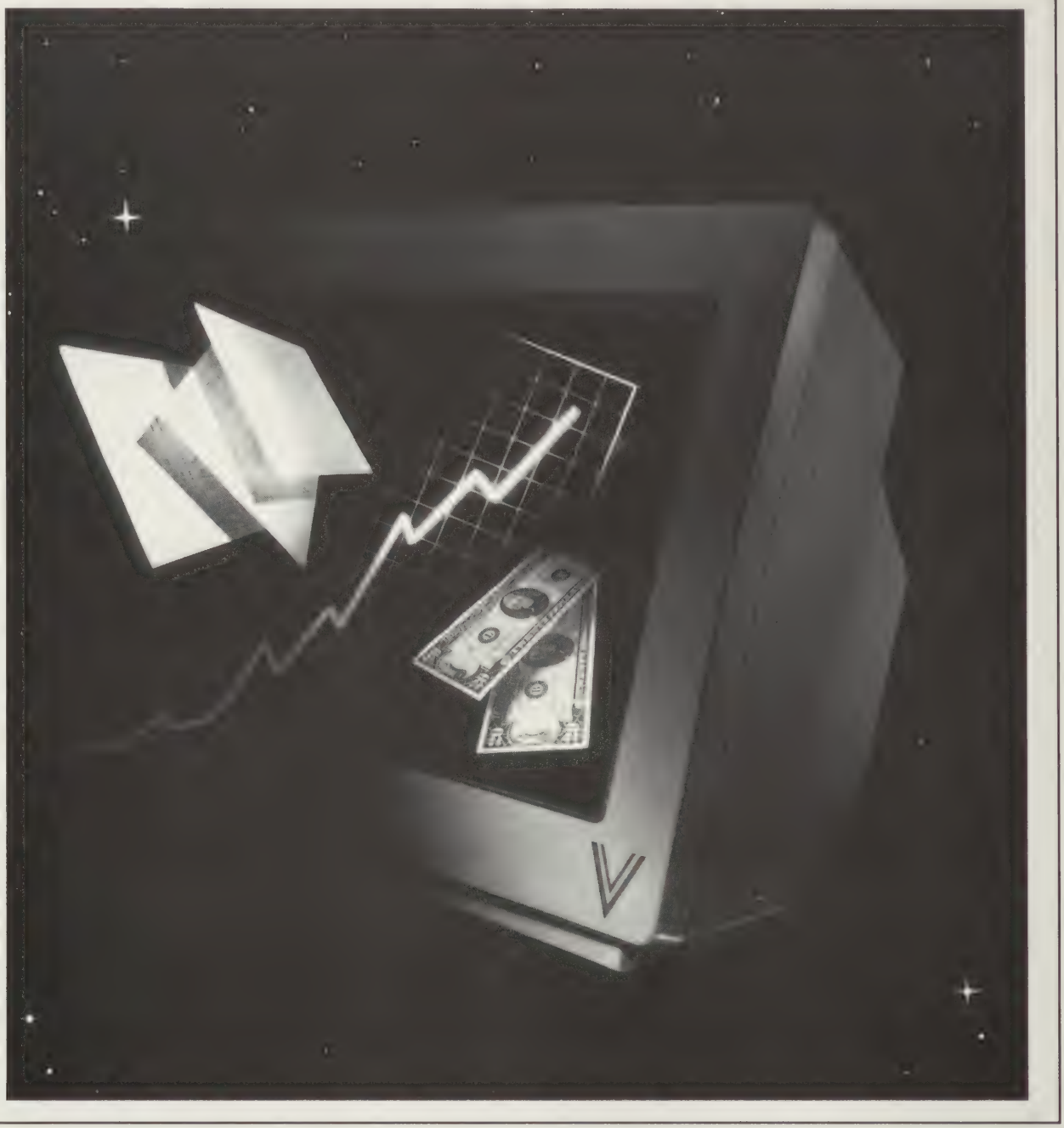
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PENNSYLVANIA MEDICINE (ISSN 0031-4595) is published monthly by the Pennsylvania Medical Society, 777 East Park Drive, Harrisburg, PA 17111.
SUBSCRIPTIONS: $20 per year–United States and Canada; $30–all others. Single issues $3.00 per copy prepaid; special issues cost more.
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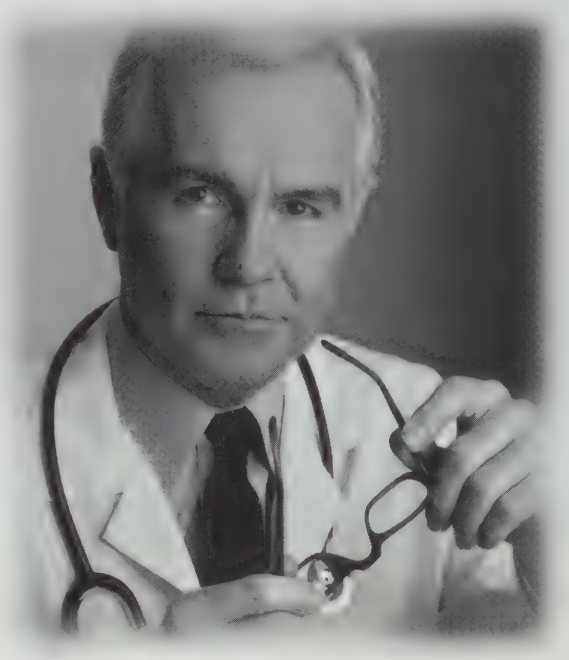
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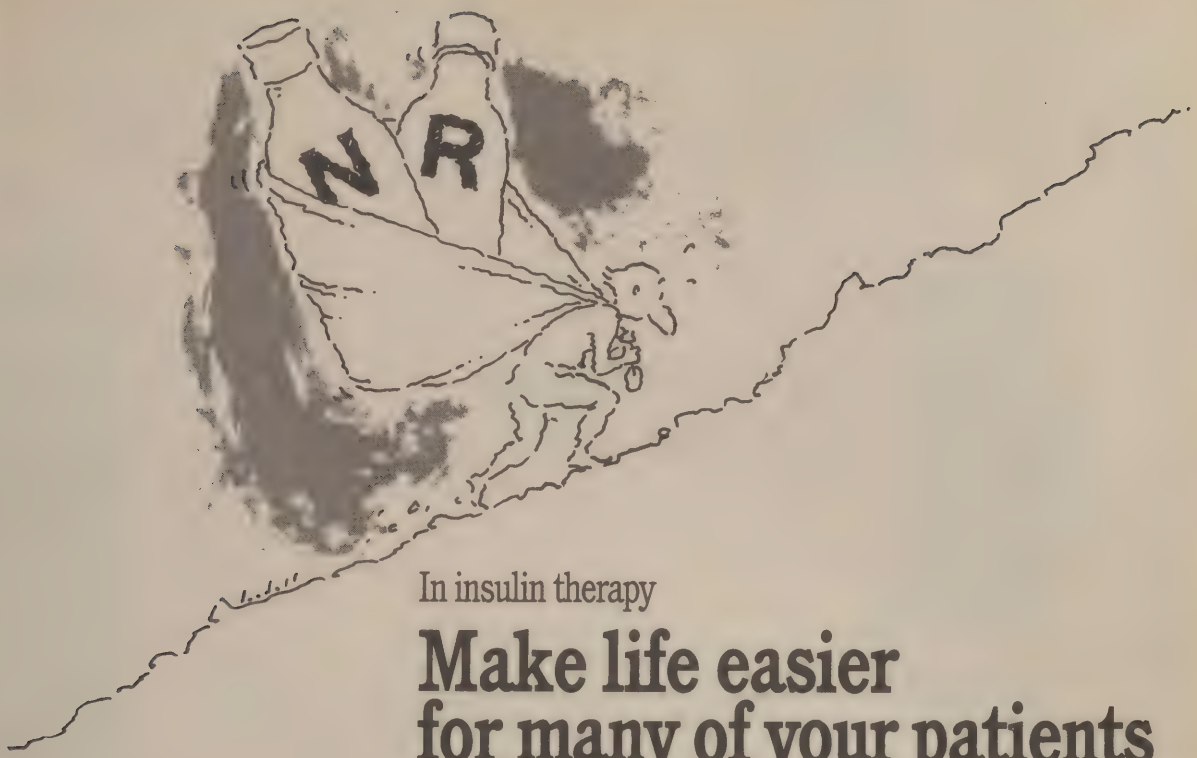


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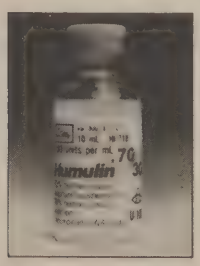
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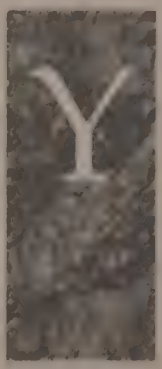
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Emory University
Atlanta, GA

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CRITICAL CARE OF THE IMMUNOSUPPRESSED PATIENT
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Assistant Professor of Medicine & Anesthesiology
Director, Medical Intensive Care Units
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Codirector, Medical Residency Program
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Hahnemann University

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October 7, 1992
Yom Kippur–No Grand Rounds

October 14, 1992
MECHANISMS OF GUT PEPTIDES IN NEUROENDOCRINE DISORDERS
Thomas O'Dorislo, M.D.
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Director, Division of Endocrinology
Ohio State University, Columbus, Ohio

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NOVEMBER 1992

November 4, 1992
HYPOTHYROIDISM: PATHOGENESIS AND IMMUNE MECHANISMS
E. Chester Ridgway, III, M.D.
Professor of Medicine
Head, Division of Endocrinology
University of Colorado Health Science Center
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November 11, 1992
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Gary S. Francis, M.D.
Professor of Medicine
Cardiovascular Division
University of Minnesota School of Medicine
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MECHANISMS AND NEW STRATEGIES FOR TREATING AUTOIMMUNE DISEASES
David Wotsy, M.D.
Associate Professor of Medicine
Chief, Rheumatology Division
San Francisco VA Medical Center
San Francisco, CA

November 25, 1992
Thanksgiving Holidays – No Grand Rounds

DECEMBER 1992

December 2, 1992
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Ronald Simon, M.D.
Associate Clinical Professor of Medicine & Pediatrics
University of California/San Diego School of Medicine
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Scripps Clinic and Research Foundation
La Jolla, CA

December 9, 1992
CHOLESTEROL REDUCTION IN PRIMARY PREVENTION: UNANSWERED QUESTIONS AND UNANSWERED ANSWERS
Jeremy Swan, M.D., Ph.D.
Professor of Medicine
UCLA School of Medicine
Los Angeles, CA

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BREAST CANCER: DIAGNOSIS AND TREATMENT
Michael P. Moore, M.D., Ph.D.
Assistant Professor of Surgery
Cornell University School of Medicine
Sloan-Kattering Cancer Center
New York, NY

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Paul Lankin, M.D.

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November 18, 1992
MECHANISMS AND STRATEGIES FOR TREATING AUTOIMMUNE DISEASES
Course Director: Richard L. Spielvogel, M.D.
Guest Faculty: Alice Gottlieb, MD
Richard P. MacDermott, M.D.
David Wotsy, M.D.

December 2, 1992
ASTHMA
Course Director: David M. Lang, M.D.
Guest Faculty: Ronald Simon, M.D.

December 16, 1992
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Pamela Crilley, D.O.
Guest Faculty: Michael P. Moore, M.D., Ph.D.

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*1849	Samuel Jackson, MD	Philadelphia County
*1850	Wilmer Worthington, MD	Chester County
*1851	Charles Innes, MD	Northampton County
*1852	Hiram Corson, MD	Montgomery County
*1853	John P. Heister, MD	Berks County
*1854	Jacob M. Grimmill, MD	Huntingdon County
*1855	James S. Carpenter, MD	Schuylkill County
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*1860-61	Edward Wallace, MD	Berks County
*1862	George F. Horton, MD	Bradford County
*1863	Wilson Jewell, MD	Philadelphia County
*1864	J. D. Ross, MD	Blair County
*1865	William Anderson, MD	Indiana County
*1866	James King, MD	Allegheny County
*1867	Traill Green, MD	Northampton County
*1868	John Curwen, MD	Dauphin County
*1869	William M. Wallace, MD	Erie County
*1870	Samuel D. Gross, MD	Philadelphia County
*1871	J. S. Crawford, MD	Lycoming County
*1872	A. M. Pollock, MD	Allegheny County
*1873	S. B. Kiefer, MD	Cumberland County
*1874	Washington L. Atlee, MD	Philadelphia County
*1875	Crawford Irwin, MD	Blair County
*1876	Robert B. Mowry, MD	Allegheny County
*1877	D. Hayes Agnew, MD	Philadelphia County
*1878	J. L. Stewart, MD	Erie County
*1879	Andrew Nebinger, MD	Philadelphia County
*1880	John T. Carpenter, MD	Schuylkill County
*1881	Jacob L. Zeigler, MD	Lancaster County
*1882	William Varian, MD	Crawford County
*1883	Henry H. Smith, MD	Philadelphia County
*1884	Ezra P. Allen, MD	Bradford County
*1885	E. A. Wood, MD	Allegheny County
*1886	Rees Davis, MD	Luzerne County
*1887	Richard J. Levis, MD	Philadelphia County
*1888-89	J. B. Murdoch, MD	Allegheny County
*1890	Alexander Craig, MD	Lancaster County
*1891	Samuel L. Kurtz, MD	Berks County
*1892	Henry L. Orth, MD	Dauphin County
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*1909	Theodore B. Appel, MD	Lancaster County
*1910	John B. Donaldson, MD	Washington County
*1911	James Tyson, MD	Philadelphia County
*1912	Lewis H. Taylor, MD	Luzerne County
*1913-14	Edward B. Heckel, MD	Allegheny County
*1915	John B. McAlister, MD	Dauphin County
*1916	Charles A. E. Codmand, MD	Philadelphia County
*1917	Samuel G. Dixon, MD	Philadelphia County
*1917	Walter F. Donaldson, MD	Allegheny County
*1918	Frederick L. Van Sickel, MD	Lackawanna County
*1919	Cyrus Lee Stevens, MD	Bradford County
*1920	Henry D. Jump, MD	Philadelphia County
*1921	Frank G. Hartman, MD	Lancaster County
*1922	Lawrence Litchfield, MD	Allegheny County
*1923	Howard C. Frontz, MD	Huntingdon County
*1924	J. Norman Henry, MD	Philadelphia County
*1925	Ira G. Shoemaker, MD	Berks County
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*1929	William T. Sharpless, MD	Chester County
*1930	Ross V. Patterson, MD	Philadelphia County
*1931	William H. Mayer, MD	Allegheny County
*1932	Charles Falkowsky Jr., MD	Lackawanna County
*1933	Donald Guthrie, MD	Bradford County
*1934	Moses Behrend, MD	Philadelphia County
*1935	Alexander H. Colwell, MD	Allegheny County
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*1939	Charles H. Henninger, MD	Allegheny County
*1940	Francis F. Borzell, MD	Philadelphia County
*1941	Lewis T. Buckman, MD	Luzerne County
*1942	Robert L. Anderson, MD	Allegheny County
*1943	Augustus S. Kech, MD	Blair County
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*1945	William L. Estes Jr., MD	Northampton County
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*1947	Elmer Hess, MD	Erie County
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*1962	W. Benson Harer, MD	Delaware County
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1970	William A. Limberger, MD	Chester County
1971	George P. Rosemond, MD	Philadelphia County
1972	Robert S. Sanford, MD	Tioga County
*1973	Ralph C. Wilde, MD	Allegheny County
*1974-75	A. Reynolds Crane, MD	Philadelphia County
1976	David S. Masland, MD	Cumberland County
1977	William J. Kelly, MD	Allegheny County
*1978	John V. Blady, MD	Philadelphia County
1979	John B. Lovette, MD	Cambria County
1980	Matthew Marshall Jr., MD	Allegheny County
1981	Leroy A. Gehris, MD	Berks County
1982	Raymond C. Grandon, MD	Dauphin County
1983	Michael P. Levis, MD	Allegheny County
1984	John Y. Templeton III, MD	Philadelphia County
*1985	D. Ernest Witt, MD	Columbia County
1986	R. William Alexander, MD	Berks County
1987	R. Robert Tyson, MD	Philadelphia County
1988	Donald E. Harrop, MD	Chester County
1989	Gerald L. Andriole, MD	Luzerne County
1990	J. Joseph Danyo, MD	York County
1991	Gordon K. MacLeod, MD	Allegheny County
1992	Robert N. Moyers, MD	Crawford County

*Deceased

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OFFICIAL CALL TO 1992 MEETING

The 1992 annual meeting of the House of Delegates of the Pennsylvania Medical Society will be called to order at the Adam's Mark Hotel, Philadelphia, Pennsylvania, on Friday, October 23, at 10:00 a.m. The second session of the House of Delegates is scheduled for Saturday, October 24, at 1:00 p.m. The third and concluding session of the House of Delegates will be held Sunday, October 25, at 9:30 a.m.

ELECTIONS

In accordance with Chapter XII, Section 1 of the Bylaws of the Pennsylvania Medical Society, the following nominations and/or elections will be in order. Nominations for AMA delegates will be in order at the first session on Friday morning, October 23, 1992, and elections will occur on Saturday morning, October 24, 1992. Nominations for all other offices will be in order at the second session, Saturday afternoon, October 24, 1992, and elections will occur on Sunday morning, October 25, 1992.

General officers to be elected are a vice president, a speaker of the House of Delegates, and a vice speaker of the House of Delegates.

In accordance with Chapter XIV, Section 5 of the Bylaws, elections will be in order for a trustee for the First District to succeed George R. Fisher, III, MD, Philadelphia County, who is eligible for reelection; a trustee for the Third District to succeed John H. Hobart, MD, Lackawanna County, who is not eligible for reelection; a trustee for the Eighth District to succeed Robert L. Lasher, MD, Erie County, who is eligible for reelection; a trustee for the Ninth District to succeed John W. Mills, MD, Indiana County, who is eligible for reelection; a trustee for the Hospital Medical Staff Section to succeed Lee H. McCormick, MD, who is eligible for reelection; a trustee for the Young Physicians Section to succeed Richard J. Greco, MD, who is eligible for reelection; and a trustee for the Medical Student Section to succeed Mark V. Caliendo, who is eligible for reelection.

If the report of the Board of Trustees regarding restructuring is adopted by the House of Delegates, an election for a trustee for the new Thirteenth District (Allegheny County) for a three-year term will also be in order.

If the proposed Bylaws amendments submitted by David E. Wiley, DO, are adopted which will redistrict Pennsylvania from twelve districts to six districts, elections will be in order for a trustee for the First District for a three-year term and for trustees for new Districts Two through Six, with straws being drawn by the Speaker to determine one, two, and three-year terms.

If the proposed Bylaws amendments submitted by Robert B. Sklaroff, MD, are adopted which would redistrict Pennsylvania from twelve districts to ten districts, Dr. Sklaroff's implementation plan calls for district trustee elections to be held as follows: 1992—First and new Fourth, Ninth, and Tenth Districts; 1993—Fifth and new Second and Eighth Districts; 1994—New Third, Sixth, and Seventh Districts. Reference Committee A will make a recommendation to the House of Delegates on the implementation plan.

In accordance with Chapter X, Section 1 of the Bylaws, elections for delegates and alternate delegates to the American Medical Association are in order. In accordance with Standing Rule Number 10 (adopted October 22, 1982), elections for delegates will be held on Saturday morning, October 24, 1992, and elections for alternate delegates will be held on Sunday morning, October 25, 1992.

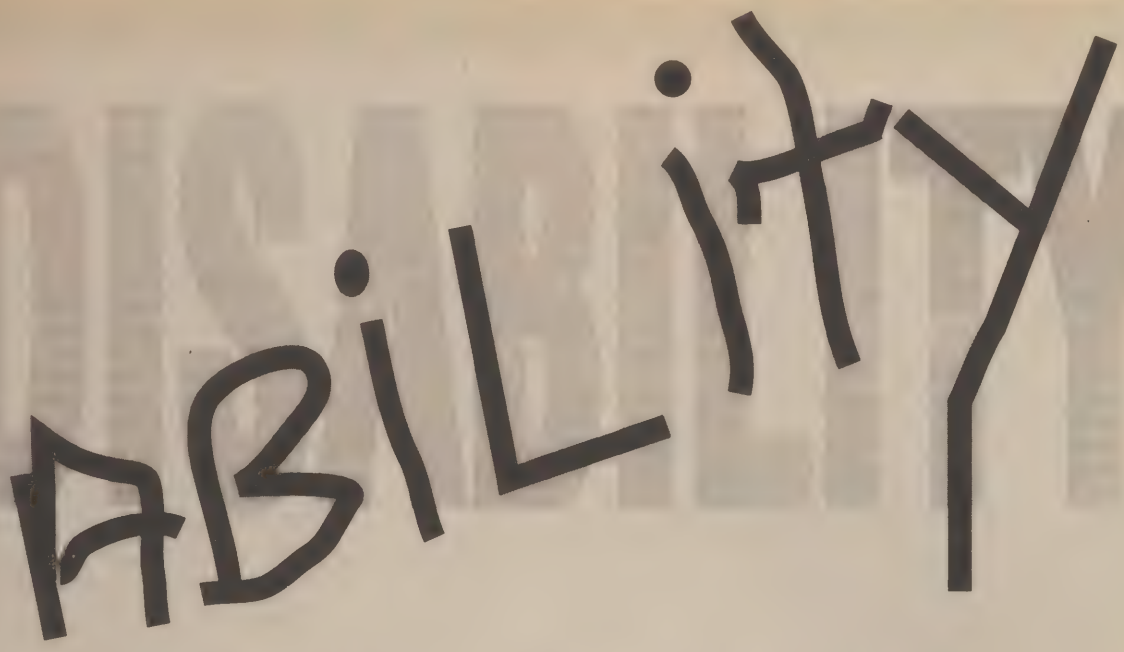
Delegates whose terms expire December 31, 1992, are:

1. R. William Alexander, MD (Berks County)
2. Doris G. Bartuska, MD (Philadelphia County)
3. Joseph B. Blood, Jr., MD (Bradford County)
4. Betty L. Cottle, MD (Blair County)
5. James B. Donaldson, MD (Philadelphia County)
6. Victor F. Greco, MD (Luzerne County)
7. Lee H. McCormick, MD (Allegheny County).
8. John S. Parker, MD (Westmoreland County)
9. Howard A. Richter, MD (Delaware County)
10. Roberta L. Schneider, MD (Montgomery County)
11. Donald H. Smith, MD (Northampton County)
12. Vacancy

The Committee to Nominate Delegates and Alternates to the AMA makes the following nominations for twelve (12) delegates for two (2) years commencing January 1, 1993, and expiring December 31, 1994:

1. R. William Alexander, MD (Berks County)
2. Richard D. Baltz, MD (Dauphin County)
3. Doris G. Bartuska, MD (Philadelphia County)
4. Joseph B. Blood, Jr., MD (Bradford County)
5. George F. Buerger, Jr., MD (Allegheny County)
6. Betty L. Cottle, MD (Blair County)
7. James B. Donaldson, MD (Philadelphia County)
8. Victor F. Greco, MD (Luzerne County)
9. Lee H. McCormick, MD (Allegheny County)
10. John S. Parker, MD (Westmoreland County)
11. Howard A. Richter, MD (Delaware County)
12. Roberta L. Schneider, MD (Montgomery County)
13. Alan H. Schragger, MD (Lehigh County)
14. Donald H. Smith, MD (Northampton County)

Alternate delegates whose terms expire December 31, 1992, are:



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1. Elias Abrutyn, MD (Philadelphia County)
2. Richard D. Baltz, MD (Dauphin County)
3. James M. Brian (Philadelphia County—Slotted Medical Student Position)
4. Charles J. Cattano, MD (Allegheny County)
5. J. Joseph Danyo, MD (York County)
6. Thomas F. Freenock, Jr., MD (Delaware County—Slotted Resident Physician Position)
7. Joseph F. Girone, MD (Philadelphia County)
8. Robert M. Kemp, MD (Lancaster County)
9. John D. Lane, MD (Bucks County)
10. John A. Malcolm, Jr., MD (Union County)
11. Carl A. Sirio, MD (Dauphin County)
12. Vacancy

The Committee to Nominate Delegates and Alternates to the AMA makes the following nominations for eleven (11) alternate delegates for two (2) year terms commencing January 1, 1993, and expiring December 31, 1994, and one (1) alternate delegate for a one (1) year term commencing January 1, 1993, and expiring December 31, 1993.

1. Elias Abrutyn, MD (Philadelphia County)
2. Isadore Brodsky, MD (Philadelphia County)
3. Winston M. Bryant, Jr., MD (Philadelphia County)
4. Charles J. Cattano, MD (Allegheny County)
5. J. Joseph Danyo, MD (York County)
6. Robert G. Doe, MD (Lancaster County)
7. Thomas F. Freenock, Jr., MD (Delaware County)
8. Julian Katz, MD (Philadelphia County)
9. Robert M. Kemp, MD (Lancaster County)
10. John D. Lane, MD (Bucks County)
11. John A. Malcolm, Jr., MD (Union County)
12. Carl A. Sirio, MD (Dauphin County)
13. Ferdinand L. Soisson, Jr., MD (Cambria County)

The Committee to Nominate Delegates and Alternates to the AMA makes the following nomination for one slotted position for alternate delegate for a medical student for a one-year term commencing January 1, 1993, and expiring December 31, 1993:

1. James M. Brian (Medical Student Section)

The Committee to Nominate Delegates and Alternates to the AMA makes the following nomination for one slotted position for alternate delegate for a resident physician for a one-year term commencing January 1, 1993, and expiring December 31, 1993:

1. Michael P. Moulton, MD (Resident Physician Section)

Also to be elected will be one member to serve on the Committee to Nominate Delegates and Alternates to the AMA. The term of Wilma C. Light, MD (Westmoreland County) expires; she is eligible for reelection.

In accordance with Chapter XVII, Section 2 of the Bylaws, the Board of Trustees nominates the following members for two vacancies on the Judicial Council. For the office now held by Kenneth L. Cooper, MD (Lycoming County), who is not eligible for reelection, the Board nominates Betty L. Cottle, MD (Blair County); James L. Harrison, MD (Lycoming County); and Charles A. Laubach, Jr., MD (Montour County). For a one-year term for the vacancy created by the death of D. Ernest Witt, MD (Columbia County), the Board nominates Henry H. Fetterman, MD (Lehigh County); Donald E. Harrop, MD (Chester County); and David L. Miller, MD (Clarion County).

Set forth below is the text of the proposed bylaws amendments. Deletions from existing bylaws are indicated by brackets; additions are italicized.

SUBJECT ONE

BOARD REDISTRICTING.

(1-A) The Board of Trustees directed the Committee on Bylaws to develop appropriate Bylaws language, for inclusion in the Official Call for consideration by the 1992 House of Delegates, creating a new Thirteenth District consisting of Allegheny County and a Tenth District consisting of Beaver, Lawrence, and Westmoreland Counties.

Chapter XIV - The Board of Trustees

Section 4 - Districts -

For purposes of this Society the counties in the Commonwealth of Pennsylvania shall be divided into the following [twelve] *thirteen* districts:

First District - Philadelphia County.

Second District - Berks, Bucks, Chester, Delaware, Lehigh, and Montgomery counties.

Third District - Carbon, Lackawanna, Monroe, Northampton, Pike, and Wayne counties.

Fourth District - Columbia, Montour, Northumberland, Schuylkill, and Snyder counties.

Fifth District - Adams, Cumberland, Dauphin, Franklin, Fulton, Lancaster, Lebanon, Perry, and York counties.

Sixth District - Blair, Centre, Clearfield, Huntingdon, Juniata, and Mifflin counties.

Seventh District - Cameron, Clinton, Elk, Lycoming, Potter, Tioga, and Union counties.

Eighth District - Crawford, Erie, Forest, Mercer, McKean, and Warren counties.

Ninth District - Armstrong, Butler, Clarion, Indiana, Jefferson, and Venango counties.

Tenth District - [Allegheny,] Beaver, Lawrence, and



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Clark Whalen has a B.A. in economics and is currently an M.B.A. candidate. His responsibility is on-going research -- tracking changes in insurance products and defining the options that are most appropriate for medical students, residents and practicing physicians.

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Westmoreland counties.
Eleventh District - Bedford, Cambria, Fayette, Greene, Somerset, and Washington counties.
Twelfth District - Bradford, Luzerne, Sullivan, Susquehanna, and Wyoming counties.
Thirteenth District - Allegheny County.

Chapter XIV - The Board of Trustees
Section 6 - Terms. . .
District trustees' terms shall be *so* arranged [so that no more than four shall expire at an annual meeting of the House of Delegates] *that at two of three annual meetings of the House of Delegates the terms of four members shall expire, and at the remaining annual meeting of the House of Delegates the terms of five members shall expire.*

(1-B) David E. Wiley, DO, proposes redistricting Pennsylvania into six trustee districts, each with approximately 3,000 members per district. The proposed language was submitted with the requisite number of signatures of active or associate members of the Society.

[Chapter XIV - The Board of Trustees
Section 4 - Districts -
For purposes of this Society the counties in the Commonwealth of Pennsylvania shall be divided into the following twelve districts:
First District - Philadelphia county.
Second District - Berks, Bucks, Chester, Delaware, Lehigh, and Montgomery counties.
Third District - Carbon, Lackawanna, Monroe, Northampton, Pike, and Wayne counties.
Fourth District - Columbia, Montour, Northumberland, Schuylkill, and Snyder counties.
Fifth District - Adams, Cumberland, Dauphin, Franklin, Fulton, Lancaster, Lebanon, Perry, and York counties.
Sixth District - Blair, Centre, Clearfield, Huntingdon, Juniata, and Mifflin counties.
Seventh District - Cameron, Clinton, Elk, Lycoming, Potter, Tioga, and Union counties.
Eighth District - Crawford, Erie, Forest, Mercer, McKean, and Warren counties.
Ninth District - Armstrong, Butler, Clarion, Indiana, Jefferson, and Venango counties.
Tenth District - Allegheny, Beaver, Lawrence, and Westmoreland counties.
Eleventh District - Bedford,



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Cambria, Fayette, Greene, Somerset, and Washington counties.
Twelfth District - Bradford, Luzerne, Sullivan, Susquehanna, and Wyoming counties.]

Chapter XIV - The Board of Trustees
Section 4 - Districts -
For purposes of this Society, the counties in the Commonwealth of Pennsylvania shall be divided into the following six districts:
First District - Philadelphia County.
Second District - Berks, Bucks, Chester, Delaware, and Montgomery counties.
Third District - Adams, Blair, Centre, Cumberland, Dauphin, Franklin, Fulton, Huntingdon, Juniata, Lancaster, Lebanon, Mifflin, Perry, and York counties.
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Fifth District - Allegheny county.
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(1-C) Robert B. Sklaroff, MD proposes redistricting Pennsylvania into ten trustee districts. The proposed language was submitted with the requisite number of signatures of active or associate members of the Society.

[Chapter XIV - The Board of Trustees
Section 4 - Districts -
For purposes of this Society the counties in the Commonwealth of Pennsylvania shall be divided into the following twelve districts:
First District - Philadelphia County.
Second District - Berks, Bucks, Chester, Delaware, Lehigh, and Montgomery counties.
Third District - Carbon, Lackawanna, Monroe, Northampton, Pike, and Wayne counties.
Fourth District - Columbia, Montour, Northumberland, Schuylkill, and Snyder counties.
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Sixth District - Blair, Centre, Clearfield, Huntingdon, Juniata,

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Eighth District - Crawford, Erie, Forest, Mercer, McKean, and Warren counties.
Ninth District - Armstrong, Butler, Clarion, Indiana, Jefferson, and Venango counties.
Tenth District - Allegheny, Beaver, Lawrence, and Westmoreland counties.
Eleventh District - Bedford, Cambria, Fayette, Greene, Somerset, and Washington counties.
Twelfth District - Bradford, Luzerne, Sullivan, Susquehanna, and Wyoming counties.]

Chapter XIV - The Board of Trustees
Section 4 - Districts -
For purposes of this Society the counties in the Commonwealth of Pennsylvania shall be divided into the following ten districts:
First District - Philadelphia County.
Second District - Bucks and Montgomery counties.
Third District - Berks, Chester, and Delaware counties.
Fourth District - Carbon, Lackawanna, Lehigh, Monroe, Northampton, Pike, and Wayne counties.
Fifth District - Adams, Cumberland, Dauphin, Franklin, Fulton, Lancaster, Lebanon, Perry, and York counties.
Sixth District - Blair, Centre, Clearfield, Columbia, Huntingdon, Juniata, Mifflin, Montour, Northumberland, Schuylkill, Snyder, and Union counties.
Seventh District - Bradford, Clinton, Luzerne, Lycoming, Potter, Sullivan, Susquehanna, Tioga, and Wyoming counties.
Eighth District - Bedford, Cambria, Fayette, Greene, Somerset, Washington, and Westmoreland counties.
Ninth District - Allegheny county.
Tenth District - Armstrong, Beaver, Butler, Cameron, Clarion, Crawford, Elk, Erie, Forest, Indiana, Jefferson, Lawrence, Mercer, McKean, Venango, and Warren counties.

SUBJECT TWO
SOCIETY LEADERSHIP.

(2-A) Dr. David E. Wiley's proposed language was submitted with the requisite number of signatures of active or associate members of the Society.

Chapter XII - Officers
Section 7 - Duties of Officers. . .
a. The president shall:
1. [be an ex officio member] *serve as chairman* of the Board of Trustees with the right to vote;
2. be an ex officio member of the House of Delegates without the right to vote;
3. be an ex officio member of all committees and commissions without the right to vote;
4. fill vacancies on administrative councils, commissions, or standing committees according to these bylaws;
5. delegate duties to the president elect, vice president, and the immediate past president;
6. file a report on the term as president with the House of Delegates at its annual meeting; [and]
7. address the House of Delegates at its annual meeting during the opening session; *and*
8. be an ex officio member of the Committee to Nominate Delegates and Alternates to the American Medical Association without the right to vote. . . .

d. The immediate past president shall:
[1. be an ex officio member of the Board of Trustees with the right to vote;]
[2.] *1.* be an ex officio member of the House of Delegates without the right to vote;
[3.] *2.* be an ex officio member of the Committee to Nominate Delegates and Alternates to the American Medical Association without the right to vote; and
[4.] *3.* perform such duties as may be delegated by the president. . .

Chapter XIV - The Board of Trustees
Section 3 - Composition -
The Board of Trustees shall consist of the president, president elect, the vice president, [the immediate past president,] the speaker of the House of Delegates, the vice speaker of the House of Delegates, ex officio with the right to vote, . . .

Chapter XIV - The Board of Trustees
Section 10 - Board Officers -
At the first meeting of the Board of Trustees after the annual meeting of the House of Delegates, it shall elect, from among the voting trustees, [a chairman,] a vice chairman and a secretary to serve until the next such meeting of the Board and until their successors are elected.

(2-B) Dr. Robert B. Sklaroff's proposed language was submitted with the requisite number of signatures of active or associate members of the Society.

Chapter XII - Officers
Section 7 - Duties of Officers. .
a. The president shall:
1. be an ex officio member of the Board of Trustees with the right to vote; *throughout the year of the term, the president shall either serve as chairperson of the Board of Trustees or shall designate a member of the Board to serve in this capacity. . . .*

Chapter XIV - The Board of Trustees
Section 10 - Board Officers -
At the first meeting of the Board of Trustees after the annual meeting of the House of Delegates, it shall elect, from

among the voting trustees, [a chairman,] a vice [chairman] *chairperson* and a secretary to serve until the next such meeting of the Board and until their successors are elected. *Throughout the year of the term, the president shall either serve as chairperson of the Board of Trustees or shall designate a member of the Board to serve in this capacity.*

SUBJECT THREE

SELECTION OF MEMBERS OF SUBSIDIARY BOARDS.

(3-A) Dr. David E. Wiley's proposed language was submitted with the requisite number of signatures of active or associate members of the Society.

Chapter X - Nominations
Section 1 - Origin of Nomination . . .

Nominations for directors of any subsidiary organization owned directly or indirectly by the Society shall be made by the Committee to Nominate Directors of Subsidiaries and published in the Official Call.

Chapter XV - Committees, Administrative Councils and Commissions
Section 2 - Standing Committees -

This Society shall have the following standing committees:... *Committee to Nominate Directors of Subsidiaries. . .*
g. Committee to Nominate Directors of Subsidiaries. The committee shall consist of five members elected by the House of Delegates to serve a term of three years. It shall be the duty of the committee to submit to the House of Delegates a list of nominees for positions as directors on subsidiary boards owned directly or indirectly in whole or in part by the Society to which the Society is entitled to appoint directors.

(3-B) Dr. Robert B. Sklaroff's proposed language was submitted with the requisite number of signatures of active or associate members of the Society.

Chapter X - Nominations
Section 1 - Origin of Nomination...

Four directors of each subsidiary board shall be elected by the House of Delegates. Two shall be elected each year for two-year terms. No individual may serve more than three successive two-year terms following election by the House of Delegates. (In 1992, two shall be elected for two-year terms and two shall be elected for one-year terms.) Nominations for directors of any subsidiary organization owned directly or indirectly by the Society shall be made by the Committee to Nominate Directors



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of Subsidiaries and published in the Official Call.

Chapter XV - Committees, Administrative Councils and Commissions
Section 2 - Standing Committees -
This Society shall have the following standing committees:. .
Committee to Nominate Directors of Subsidiaries. . .
g. Committee to Nominate Directors of Subsidiaries. The committee shall consist of five members elected by the House of Delegates to serve a term of three years. It shall be the duty of the committee to submit to the House of Delegates a list of nominees for positions as directors on subsidiary boards owned directly or indirectly in whole or in part by the Society to which the Society is entitled to appoint directors.

SUBJECT FOUR

ONE PERSON, ONE JOB RULE.
Dr. David E. Wiley's proposed language was submitted with the requisite number of signatures of active or associate members of the Society.

Chapter V - Separation of Powers
Section 4 - Maintaining Separation of Powers -
To maintain the separation of powers *and encourage participation in the Society,* [of the three divisions] the following restrictions shall prevail:
a. [A member of this Society, if a voting member of the House of Delegates, may not at the same time serve on the Judicial Council, as a trustee of the Board of Trustees, or as president, immediate past president, president elect, vice president, treasurer, secretary, or speaker or vice speaker of the House of Delegates.
b. A member of this Society may not concurrently hold more than one office of this Society.
c.] A member of the Judicial Council may not at the same time serve as a voting member of the House of Delegates or the Board of Trustees except as provided in Chapter XVII, Section 2, or as president, immediate past president, president elect, vice president, treasurer, or secretary of this Society, or as speaker or vice speaker of the House of Delegates, or as a district censor, or as a member of any council, commission, or administrative committee. A member of the Judicial Council however may be elected or appointed to a council or committee which nominates persons to hold office or receive awards, or which is purely advisory in nature.
A member of this Society may serve concurrently on only one of the following: the Board of Trustees, the delegation to the American Medical Association, or any council committee, or commission of the Society, any Board of Directors on any corporation owned directly or indirectly by the Society or to which the Society may appoint directors directly or indirectly. The board shall be limited to an executive and finance committee composed of its own members. The board may appoint one, and only one, ex officio member to any council, committee, or task force. Further, the councils, committees, and boards above listed may request a member of another to serve as a consultant without right to vote.

SUBJECT FIVE

VOTING STATUS OF THE SPEAKER AND VICE SPEAKER OF THE HOUSE OF DELEGATES.
Dr. David E. Wiley's proposed language was submitted with the requisite number of signatures of active or associate members of the Society.

Chapter XII - Officers
Section 7 - Duties of Officers.
i. The speaker of the House of Delegates: . . .
6. shall be ex officio with*out* the right to vote on the Board of Trustees; . . .

j. Vice speaker of the House of Delegates: . . .
4. shall be ex officio with*out* the right to vote on the Board of Trustees; . . .

Chapter XIV - The Board of Trustees
Section 3 - Composition -
The Board of Trustees shall consist of the president, president elect, the vice president, *and* the immediate past president *as voting members, and* the speaker of the House of Delegates[,] *and* the vice speaker of the House of Delegates, ex officio with*out* the right to vote, . . .

SUBJECT SIX

CHANGE IN PMS BOARD STRUCTURE TO LIMIT TRUSTEES TO TWO THREE-YEAR TERMS.
Dr. David E. Wiley's proposed language was submitted with the requisite number of signatures of active or associate members of the Society.

Chapter XIV - The Board of Trustees
Section 6 - Terms. . .
No trustee may serve more than [three] *two* consecutive terms. A trustee elected to serve an unexpired term shall not be regarded as having served a term unless he has served more than one year. A year is deemed to be the period of time between consecutive annual meetings of the House of Delegates. *(A trustee who was serving his third term prior to October 1992 may complete that term.)*

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Department of Energy
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Department of Labor
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Washington, DC 20210
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Library, Room N2439, 523-6992

Congress

Legislative Information Services
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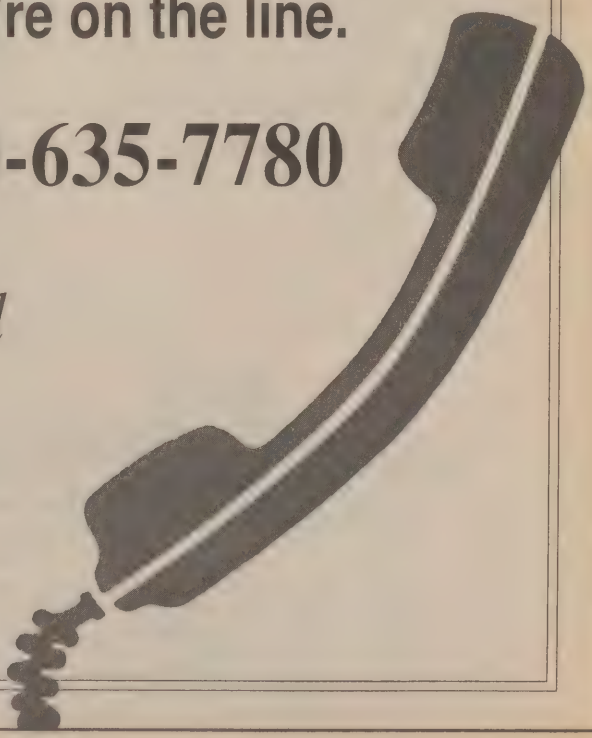
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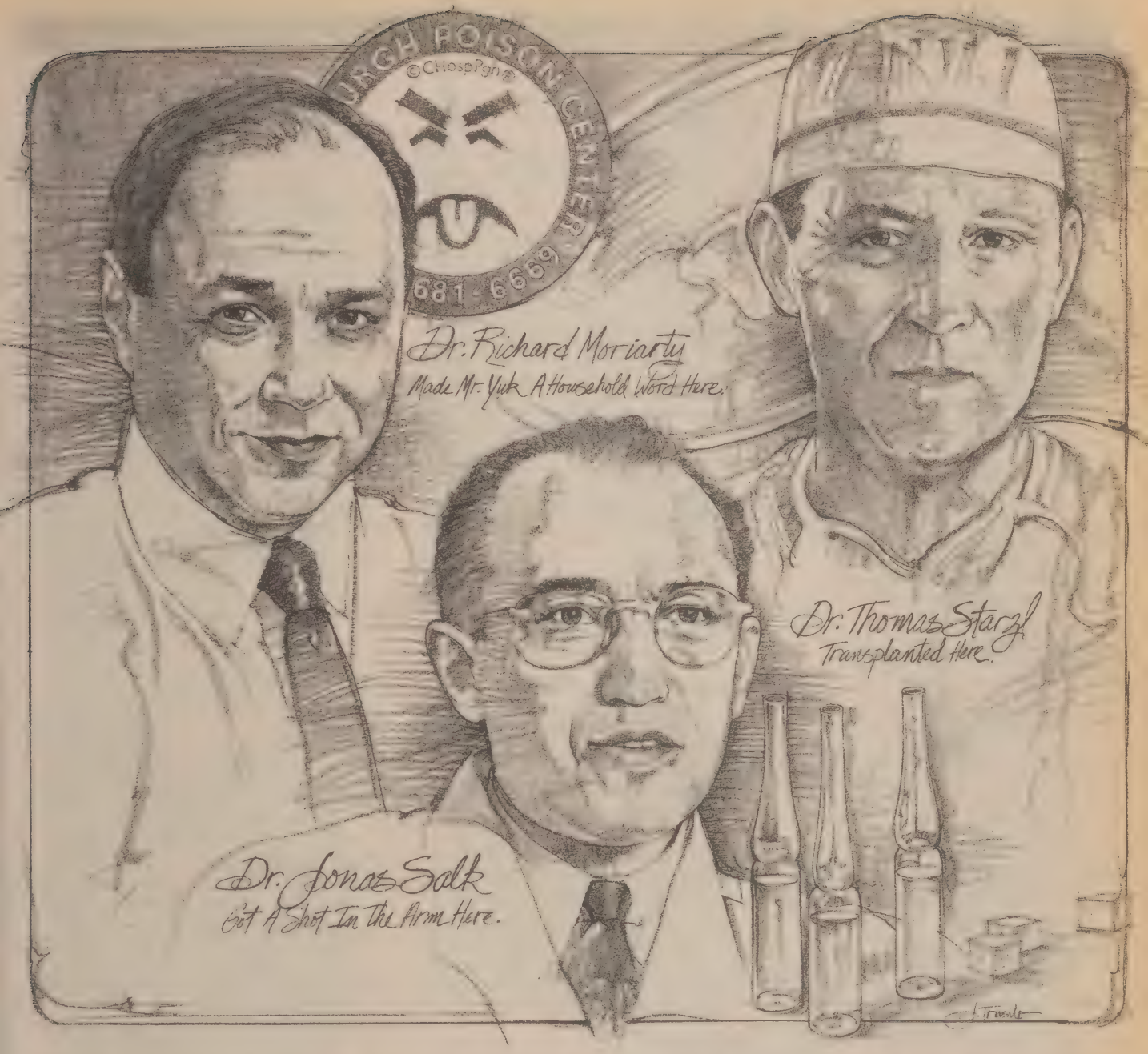
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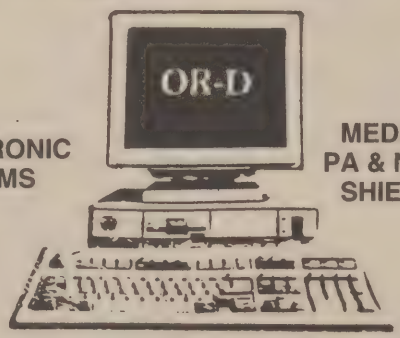
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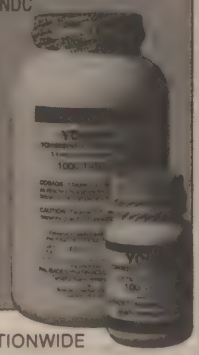
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Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

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References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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The House of Delegates of the Pennsylvania Medical Society will convene its annual meeting at the Adam's Mark Hotel, Philadelphia, Pennsylvania, on Friday, October 23, 1992. The second session will convene Saturday, October 24, 1992, and the third session Sunday, October 25, 1992. Details regarding the starting times appear in the Official Call, which begins on page 18 of this issue of PENNSYLVANIA MEDICINE.

Resolutions to be considered by the House may be submitted in writing to the Secretary by a delegate acting in his/her own behalf or for the component medical society or specialty society he/she represents. If received prior to September 23, 1992, resolutions will be published in the *Official Reports Book*.

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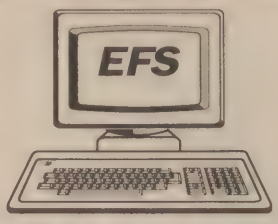
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*** Indicates membership in the Pennsylvania Medical Political Action Committee**

ADL	Adolescent Medicine	2
AI	Allergy and Immunology	74
AM	Aerospace Medicine	3
A	Allergy	53
AN	Anesthesiology	863
ATP	Anatomic Pathology	5
BE	Broncho-Esophagology	1
BLB	Blood Banking	2
CCM	Critical Care Medicine	7
CD	Cardiovascular Diseases	737
D	Dermatology	271
DMP	Dermatopathology	4
DIA	Diabetes	21
EM	Emergency Medicine	334
END	Endocrinology	82
FP	Family Practice	1,758
FPS	Facial Plastic Surgery, Otolaryngology	3
GE	Gastroenterology	280
GO	Gynecological Oncology	5
GP	General Practice	945
GPM	General Preventive Medicine	19
GER	Geriatrics	49
GYN	Gynecology	80
HEM	Hematology	96
IG	Immunology	1
ID	Infectious Diseases	80
IM	Internal Medicine	2,386
LAR	Laryngology	1
LM	Legal Medicine	3
MFM	Maternal & Fetal Medicine	4
MFS	Maxillofacial Surgery	2
ND	Neoplastic Diseases	6
NEP	Nephrology	114
N	Neurology	257
NPM	Neonatal-Perinatal Medicine	31
CHN	Neurology, Child	6
NA	Neuropathology	2
NM	Nuclear Medicine	50
NR	Nuclear Radiology	1
NTR	Nutrition	4
OBS	Obstetrics	2
OBG	Obstetrics/Gynecology	1,017
OM	Occupational Medicine	97
ON	Oncology	156
OPH	Ophthalmology	713
OT	Otology	3
OTO	Otolaryngology	310
PTH	Pathology	365
CLP	Pathology, Clinical	27
FOP	Pathology, Forensic	2
PD	Pediatrics	869
PDA	Pediatrics, Allergy	17
PDC	Pediatrics, Cardiology	15
PDE	Pediatric Endocrinology	1
PHO	Pediatric Hematology-Oncology	2
PNP	Pediatric Nephrology	2
PVD	Peripheral Vascular Diseases	6
PA	Pharmacology, Clinical	18
PM	Physical Medicine/Rehabilitation	293
P	Psychiatry	708
CHP	Psychiatry, Child	67
PYA	Psychoanalysis	20
PYM	Psychosomatic Medicine	1
PH	Public Health	19
PUD	Pulmonary Diseases	189
RO	Radiation Oncology	30
R	Radiology	483
DR	Radiology, Diagnostic	482
PDR	Radiology, Pediatric	6
TR	Radiology, Therapeutic	75
REN	Reproductive Endocrinology	2
RHU	Rheumatology	131
ABS	Surgery, Abdominal	8
CDS	Surgery, Cardiovascular	93
CRS	Surgery, Colon and Rectal	61
GS	Surgery, General	1,098
HS	Surgery, Hand	18
HNS	Surgery, Head and Neck	8
NS	Surgery, Neurological	178
ORS	Surgery, Orthopedic	720
PDS	Surgery, Pediatric	20
PS	Surgery, Plastic	180
TS	Surgery, Thoracic	108
TRS	Surgery, Traumatic	11
U	Surgery, Urological	380
VS	Surgery, Vascular	48
OS/US	Other, i.e., physician designated a specialty other than those appearing above. Unspecified.	311
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120 RIDGEVIEW DR
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321 LIMEKILN RD
READING PA 19606-3435
215-378-2000

COHN, MD, C HAROLD TS
1130 GARFIELD AVE
WYOMISSING PA 19610-2219

COLMENARES, MD, RUPERTO F P
AVENIDA 15 NO 127-34
BOGOTA COLOMBIA SA

COMESS, MD, RAYMOND R GS
1801 ECKERT AVE
READING PA 19602-1405

CONNERTON, MD, GEORGE E PTH
1921 STURBRIDGE DR
WYOMISSING PA 19610-2678
215-378-8348

CONSOLI, MD, DEBORAH P * OBG
640 WALNUT ST STE 301
READING PA 19601-3525
215-378-6666

COPE, MD, DAVID A OTO
301 S 7TH AVE
WEST READING PA 19611-1410
215-376-9728

CRAIG, MD, PAUL C OPH
PENNSWOOD VILLAGE APT 1130
NEWTOWN PA 18940

CRAMP, MD, LLOYD L GS
15 CONGRESSIONAL CIR
READING PA 19607-3418

CRANDALL, MD, TONIE L OBG
301 S 7TH AVE STE 245
WEST READING PA 19611-1451
215-374-2214

DALY, MD, DAVID G IM
110 N QUARRY ST
ITHACA NY 14850
607-273-4055

DASHE, MD, MYER M * GP
1700 HAMPDEN BLVD
READING PA 19604-1604

DEBENEDICTIS, MD, KENNETH J ID
301 S 7TH AVE
WEST READING PA 19611
215-374-8523

DEIBERT, MD, DAVID C END
580 VAN REED RD STE 304
WYOMISSING PA 19610-1799
215-373-7743

DELP JR, MD, CHARLES W FP
810 E PHILADELPHIA AVE
BOYERTOWN PA 19512-1307
215-367-2259

DELVECCHIO, MD, LEONARD M FP
103 AUGUSTA CIR
KERRVILLE TX 78028-6512

DENBY, MD, ROBERT A GP
25 STEVENS AVE
WEST LAWN PA 19609-1400
215-678-4455

DENGLER, MD, ERNEST H OPH
STAPELEY IN GERMANTOWN
PHILADELPHIA PA 19144-2596

DERR, MD, CRAIG A IM
580 VAN REED RD
WYOMISSING PA 19610-1799
215-378-1601

DERSH, MD, JEROME OPH
506 COURT ST STE 200
READING PA 19601-3542
215-374-5685

DESJARDINS, MD, GEORGE P PTH
504 CARSONIA AVE
READING PA 19606-1521

DETHOFF, MD, JOHN C ORS
200 N 13TH ST STE 105
READING PA 19604-2954
215-375-8471

DEVINE, MD, RAYLENE A PD
8 W PENN AVE
WERNERSVILLE PA 19565-1502
215-670-2141

DIETRICH, DO, LEONARD M GP
15250 KUTZTOWN RD PO BOX 243
KUTZTOWN PA 19530-0243
215-683-8085

DIETRICH, DO, MARCIA C GP
31 PINE LN
DOUGLASSVILLE PA 19518-1302
215-582-8922

DIETRICH, MD, SCOTT A * FP
142 VICTORIA LN
WYOMISSING PA 19610-1456
215-569-3555

DIRENZO, MD, DENNIS P PD
40 BERKSHIRE CT
WYOMISSING PA 19610-1224
215-374-7400

DONNELLY JR, MD, JOSEPH C TS
200 N 13TH ST STE 307
READING PA 19604-2958
215-375-0606

DONOVAN, MD, ROBERT S FP
RR 6050
SINKING SPRING PA 19608
215-926-2186

DOOLEY, MD, THOMAS W PS
1754 GARFIELD AVE
WYOMISSING PA 19610-2334
215-796-1000

DRAKES, MD, GEORGE H PM
MORGANTOWN RD
READING PA 19607

DUDA, MD, ANDREW M * TS
11 PHOEBE DR
WYOMISSING PA 19610-2858
215-375-1629

DUFFY, MD, SCOTT S * IM
301 S 7TH AVE
WEST READING PA 19611-1410
215-378-8004

EAGER, MD, J MICHAEL * OBG
1340 PENN AVE
WYOMISSING PA 19610-2132
215-375-4241

EARLY JR, MD, ROBERT F AN
1800 BERN ST
READING PA 19604-1632
215-378-8260

EBERSOLE, MD, THOMAS M * OBG
640 WALNUT ST STE 310
READING PA 19601-3525
215-378-6666

EDMUNDS, MD, ELIZABETH H FP
514 CARSONIA AVE
READING PA 19606-1521
215-779-8822

EMKEY, MD, KENNETH D * GE
301 S 7TH AVE STE 215
WEST READING PA 19611-1450
215-374-4401

EMKEY, MD, RONALD D RHU
401 BUTTONWOOD ST
WEST READING PA 19611-1101
215-375-4251

ERDEK JR, MD, MICHAEL A US
122 WALL ST APT C
DANVILLE PA 17821

ERMOLD, MD, DONALD R GP
425 E LANCASTER AVE
SHILLINGTON PA 19607-1363
215-777-7041

ERTEL, MD, D GREGORY * GE
301 S 7TH AVE STE 45
WEST READING PA 19611
215-374-4401

ESKAROUS, MD, NADY I FP
200 N 13TH ST
READING PA 19604-2961
215-378-2080

FALLON III, MD, EDWARD C DR
READING HOSPITAL & MED CENTER
READING PA 19612-6052
215-378-6108

FARBER, MD, DAVID N OPH
506 COURT ST STE 200
READING PA 19601-3542
215-374-5685

FARBER, MD, ERIC B OPH
506 COURT ST STE 200
READING PA 19601-3542
215-374-5685

FARBER, MD, HAROLD I IM
1511 HAMPDEN BLVD
READING PA 19604-1629

FARRY, MD, KIMBERLY M OBG
52 FAHNESTOCK RD
MALVERN PA 19355-2133
215-378-8881

FAUST, MD, DONALD S TR
READING HOSPITAL & MED CENTER
READING PA 19603
215-378-6067

FEASTER, MD, MARSHALL M CDS
1235 PENN AVE
WYOMISSING PA 19610-2100
215-374-5000

FEHNEL, MD, STEPHEN H OBG
301 S 7TH AVE
WEST READING PA 19611-1410
215-374-2214

FEICK, MD, RALPH H FP
WILLOW VALLEY ESTATES
WILLOW STREET PA 17584-9205

FEINBERG, MD, STANFORD S * N
290 RIDINGS WAY
BROAD AXE PA 19002-5246
215-378-5428

FERRY, MD, GERALD W * OBG
200 N 13TH ST STE 304
READING PA 19604-2958
215-378-5200

FISCHER, MD, EDWARD C R
READING HOSPITAL & MED CENTER
READING PA 19603
215-378-6108

FISHER, DO, CLAUDIA C FP
RD 8 BOX 221
SINKING SPRING PA 19608
215-378-8000

FLEISCHER, MD, ALAN N U
200 N 13TH ST
READING PA 19604-2961
215-372-2351

FLORES, MD, EVELYN R N
200 N 13TH ST STE 311
READING PA 19604-2954
215-376-3981

FOLDES-ROTH, MD, ELISABETH GYN
3300 DARBY RD # 7203
HAVERFORD PA 19041-1074

FRANCO, MD, FRANK A IM
102 N 11TH ST
READING PA 19601-3707

FRANCOIS, MD, MAX B GP
2021 FRANKLIN PL
WYOMISSING PA 19610-1425
215-478-9600

FRANK, MD, JEFFREY B OBG
301 S 7TH AVE
WEST READING PA 19611-1410
215-374-2214

FRANTZ, MD, ROBERT C OM
532 S PARK RD
WYOMISSING PA 19610-2276

FRIEDMAN, MD, ELLIS F * ORS
320 ABINGTON DR
WYOMISSING PA 19610-1898
215-678-4525

FUSCO-RIPKA, MD, GIOVANNA D OS
1216 MEADE ST
READING PA 19611-1852

GALLEN, MD, JOHN H GP
2950 VAN REED RD
SINKING SPRING PA 19608-1035
215-678-7000

GANSNER, MD, ROBYN K PM
READING REHAB HOSP
READING PA 19607-9727
215-777-7615

GARCIA, MD, ANTONIO S GP
PO BOX 185
HAMBURG PA 19526-0185
215-562-3133
GEHMAN, MD, M JACK GP
255 E WYOMISSING AVE
READING PA 19607-3262
GEHRIS, MD, LEROY A FP
HIGHLANDS AT WYOMISSING
WYOMISSING PA 19610-2714
215-775-4471
GEORGE, MD, DAVID L RHU
DEPT OF MEDICINE RHMC
READING PA 19612-6052
215-378-6000
GERHART, MD, GEORGE R FP
3351 PERKIOMEN AVE
READING PA 19606-2736
215-779-3500
GEYER, MD, DAVID W *AN
1539 READING BLVD
WYOMISSING PA 19610-2443
215-378-6269
GHALY, MD, NADER N CD
5 CRESTHILL CT
VOORHEES NJ 08043-2832
215-842-8959
GIACCIA, MD, AMATO GP
600 SCHUYLKILL AVE
READING PA 19601-2640
215-373-1618
GIERINGER, MD, ROBERTA L IM
423 SUNSET RD
WEST READING PA 19611-1307
GIESECKE, MD, SUSAN B DR
1634 MEADOWLARK RD
WYOMISSING PA 19610-2821
215-378-2230
GILBERT, MD, STEVEN L DR
1033 MOUNT HOLYOKE PL
SWARTHMORE PA 19081
GILFILLAN III, MD, A GEORGE PD
1125 BERKSHIRE BLVD STE 100
WYOMISSING PA 19610-1232
215-376-8691
GINSBERG, MD, GARY U
606 COURT ST STE 308
READING PA 19601-3002
215-375-4542
GLOSSER, MD, WILLIAM E EM
1240 DAUPHIN AVE
WYOMISSING PA 19610-2112
GORDON, MD, MICHAEL E *R
COMMUNITY GEN HOSP DEPT RAD
READING PA 19601
215-378-8355
GRABIAS, MD, STANLEY L ORS
301 S 7TH AVE STE 100
WEST READING PA 19611-1449
215-375-6226
GRAHAM, MD, BARRY E *OBG
1340 PENN AVE
WYOMISSING PA 19610-2132
215-375-4241
GRANADOS, MD, NICANOR G IM
1555 SCHUYLKILL AVE
READING PA 19601-1312
215-378-0107
GRANADOS, MD, BUZITA N PD
130 PROSPECT ST
READING PA 19606-2866
215-779-4786
GREENBERG, MD, ROBERT N GS
200 N 13TH ST STE 204
READING PA 19604-2955
215-378-8244
GREENE, MD, LUCILLE T *GP
412 N 12TH ST
READING PA 19604-2821
215-374-2435
GREENE, MD, RICHARD J *PDA
39 E LANCASTER AVE
SHILLINGTON PA 19607
215-777-9883
GREGORY, MD, GEORGE W CDS
1235 PENN AVE
WYOMISSING PA 19610-2100
215-374-5000
GRETH, MD, WARREN E RHU
109 LOGAN AVE
WYOMISSING PA 19610-2617
215-375-4251
GRIM, MD, MARK D GP
MAIN ST
OLEY PA 19547-0277
GROSS, MD, LAWRENCE S PD
10 FAIRLANE RD
READING PA 19606-9562
215-779-9550
GRUBB, MD, WILLARD Y FP
143 W PHILADELPHIA AVE
BOYERTOWN PA 19512-1429
GRUBER, MD, JOHN W CD
301 S 7TH AVE
WEST READING PA 19611-1410
215-375-6565
HANGEN, MD, NORMAN M GP
GREENFIELDS
READING PA 19601-1002
HANNA, MD, EZZAT A FP
PO BOX 347
SHILLINGTON PA 19607-0347
215-775-2799

HANNA, MD, TONY A FP
421 SUNSET RD
WEST READING PA 19611
215-378-2000
HANNA, MD, WAFA S FP
352 OAKWOOD DR
WHITEHALL PA 18057
215-378-2080
HARRIS, MD, LAWRENCE K CD
COMMUNITY GENERAL HOSPITAL
READING PA 19602-3541
215-375-4679
HARRISON, MD, DIANE D ONC
115 PLYMOUTH CT
WYOMISSING PA 19610
215-375-4241
HASSAN, MD, JOSEPH R IM
4201 KUTZTOWN RD
TEMPLE PA 19560-1836
215-921-2094
HASSEL, MD, JEFFREY L IM
640 WALNUT ST STE 305
READING PA 19601-3525
215-376-9748
HASSLER, MD, CARL W FP
606 WELLINGTON AVE
READING PA 19609-2342
215-777-2643
HAUSER, MD, RAYMOND J *FP
THE LUTHERAN HOME
TOPTON PA 19562
215-682-2145
HAWKE, MD, WILLIAM *AN
29 FLINT RIDGE DR
SHILLINGTON PA 19607-3016
215-378-6589
HEFFERNAN, MD, J MICHAEL IM
560 VAN REED RD
WYOMISSING PA 19610-1799
215-378-1601
HEIDEN, MD, RICHARD A *R
CGH DEPT OF RADIOLOGY
READING PA 19601-3501
215-378-8415
HEIN, MD, EDWARD W AI
BERKSHIRE ALLERGY AND ASTHMA
WYOMISSING PA 19610
215-375-6708
HEISEY, MD, JOHN C *IM
1008 BEN FRANKLIN HWY W
DOUGLASSVILLE PA 19518
215-582-1524
HELINEK, MD, GERARD L PD
READING HOSPITAL & MED CENTER
READING PA 19612
215-378-6108
HELINEK, MD, THOMAS G DR
1106 SPRUCE ST
PHILADELPHIA PA 19107
215-955-2788
HELLER, MD, FREDERICKA S M OBG
530 KENHORST BLVD
READING PA 19611-1716
215-775-7133
HENNINGER, MD, WILLIAM H AN
189 OAKMONT CT
READING PA 19607-3406
HERB, DO, RONALD K IM
512 LINDEN ST
LEESPORT PA 19533
HERMANOVICH JR, MD, JOHN CD
301 S 7TH AVE STE 205
WEST READING PA 19611-1450
215-375-6565
HEY JR, MD, E BERRY CD
301 S 7TH AVE STE 205
WEST READING PA 19611-1450
215-375-6565
HIEHLE, MD, J FREDERICK *R
301 S 7TH AVE
WEST READING PA 19611-1410
215-678-6108
HIGH, MD, BERTRAND J IM
11A FLYING HILLS VILLAGE CTR
FLYING HILLS PA 19607
215-775-4500
HIMMELSTEIN, MD, FRED R *EM
825 REDWOOD AVE
WYOMISSING PA 19610-1415
215-378-8367
HOCH, MD, WILLIS S PTH
444 DONALYN LN
BERWYN PA 19312-1007
215-373-2544
HOFFMAN, MD, DAVID A OS
1330 PENN AVE
WYOMISSING PA 19610-2132
215-373-4271
HOFFMAN, MD, NEIL A PTH
READING HOSP AND MEDICAL CTR
READING PA 19612-6052
215-378-6088
HOLM, MD, ERIC K *NS
606 MUSEUM RD
READING PA 19611-1427
215-373-4007
HORST, MD, ELMER L P
715 LAKE AVE
WYOMISSING PA 19610-2429
HORTON, MD, DAVID J FP
122 N 4TH ST
HAMBURG PA 19526
215-562-4092

HOYT, MD, RALPH C GE
RR 3 BOX 3063
BIRDSBORO PA 19508-9547
HUBBARD, MD, RAYMOND J PD
4 LONGVIEW DR
BIRDSBORO PA 19508-9390
215-374-7400
HUNTER, MD, JOHN S GP
2000 CAMBRIDGE AVE APT 84
WYOMISSING PA 19610-2714
IMBER, MD, IRVING IM
1422 ROSE VIRGINIA RD
READING PA 19611-1738
IMPINK, MD, ROBERT R GS
125 ORCHARD PL
SHILLINGTON PA 19607-3226
INNIS, MD, PATRICIA A FP
900 N 5TH ST
READING PA 19601-1802
215-375-1818
IZZO, MD, DOMENIC C OPH
560 VAN REED RD STE 102
WYOMISSING PA 19610-1799
215-372-0712
JACOBSON, MD, MARTIN A IM
4201 KUTZTOWN RD
TEMPLE PA 19560-1836
215-921-2094
JAMES, MD, EDWARD K NPM
READING HOSPITAL
READING PA 19612-6052
215-378-6843
JAMES, MD, JEFFREY R IM
1650 PENN AVE APT D
WYOMISSING PA 19610-2347
215-678-6861
JAMES, MD, NARENDRA N FP
520 OLEY ST
READING PA 19601-2224
215-378-2440
JAXHEIMER, MD, ERIC C VS
801 S TRENT AVE
WYOMISSING PA 19610-2253
215-378-9667
JAY JR, MD, W THOMAS IM
516 LYNNE AVE
READING PA 19610-2225
JENCKES III, MD, GEORGE A *IM
345 GREEN BRIAR LN
WYOMISSING PA 19610
215-777-7827
JIMERSON, MD, CEDRIC C GS
RR 5 BOX 354
SINKING SPRING PA 19608-9805
JOHNSON, MD, ALFRED T FP
2240 PENN AVE
WEST LAWN PA 19609-1650
215-678-8596
JOHNSON, MD, CRAIG H NS
301 S 7TH AVE STE 365
WEST READING PA 19611-1436
215-373-5138
JOHNSON, MD, WILLIAM T *AN
170 WHITE HALL RD
REINHOLDS PA 17569-9738
215-378-6589
JONES, DO, JEFFREY J FP
51 CENTRE AVE
TOPTON PA 19562-1001
KANE, DO, PATRICIA B *PD
WINSOME ACRES
SCHUYLKILL HAVEN PA 17972-9348
215-374-4491
KAPLAN, MD, LAWRENCE M *DR
COMMUNITY GENERAL HOSPITAL
READING PA 19601-3501
215-373-3100
KAPLAN, MD, ROBIN L PUD
ST JOSEPH HOSPITAL
READING PA 19603
215-929-2433
KAPLAN, MD, SHELDON J OPH
WEST READING OPHTHALMIC ASSOC
WEST READING PA 19611-1498
215-378-1344
KARABELNIK, MD, DON FP
325 E LANCASTER AVE
SHILLINGTON PA 19607-2633
215-775-3316
KASE, MD, JAMES J IM
112 N 11TH ST
READING PA 19601-3707
215-376-9112
KASTENBAUM, MD, MICHAEL IM
101 W LANCASTER AVE
SHILLINGTON PA 19607-1857
215-777-6516
KEARNEY, MD, JOHN M GS
1130 SHELBOURNE RD
READING PA 19606-9771
KEFFER, MD, WILLIAM H OS
1424 MONROE AVE
WYOMISSING PA 19610-2436
KEISER, MD, E LEE GP
310 GRACE COMMUNITY
MYERSTOWN PA 17067-2208
717-866-3639
KELLER, MD, LYNWOOD V GP
MEDICAL DIRECTOR BERKS HEIM
WYOMISSING PA 19610
215-376-4841

KERSHNER, MD, MARILYN S R
READING HOSPITAL & MED CENTER
READING PA 19603
215-378-6108
KHANDAKER, MD, DILARA Z FP
200 N 13TH ST STE 100
READING PA 19604-2954
215-378-2660
KILCHEVSKY, MD, EITAN S PD
2017 REGENCY DR
READING PA 19610-2712
215-378-6843
KILLIAN III, MD, CALEB L *FP
2508 HAMPDEN BLVD
READING PA 19604-1009
215-921-3924
KIM, MD, CHUNG S *IM
140 W WINDSOR ST
READING PA 19601-2059
215-376-2230
KIMBALL, MD, C EVE J PD
1303 ORCHARD RD
READING PA 19611-1437
215-372-9222
KIMBALL JR, MD, DANIEL B *IM
DIRECTOR DEPT OF MEDICINE
READING PA 19612-6052
215-378-6133
KIMMEL, MD, CRAIG A OTO
301 S 7TH AVE
WEST READING PA 19611-1410
215-376-9728
KLEIN JR, MD, WILLIAM J NEP
301 S 7TH AVE
WEST READING PA 19611-1410
215-376-7365
KLEINER, MD, ANTON J *GYN
301 S 7TH AVE
WEST READING PA 19611-1410
215-375-8493
KLEPPINGER, MD, RICHARD K GYN
301 S 7TH AVE
WEST READING PA 19611-1410
215-374-2214
KLOMBERG, MD, LEE A OPH
206 S 6TH AVE
WEST READING PA 19611-1498
215-378-1344
KNIAZER, MD, BARRY OBG
613 DAVIS RD
CHELTENHAM PA 19012-1636
KOCHU, MD, STEVE END
580 VAN REED RD
WYOMISSING PA 19610-1799
215-373-7743
KOHL, MD, STEPHEN D *OBG
640 WALNUT ST STE 301
READING PA 19601-3525
215-375-5555
KOLTON, MD, VLADIMIR J GP
1448-50 SPRUCE ST
READING PA 19602
215-375-4755
KOREY JR, MD, JOSEPH J OBG
250 N 12TH ST
READING PA 19604-2952
215-374-0970
KOVALSKY, MD, KENNETH FP
9 BRISTOL CT
WYOMISSING PA 19610-1805
215-670-2222
KRALJEVIC, MD, JUAN E IM
403 N 13TH ST
READING PA 19604-2822
215-375-8577
KRAWITZ, MD, PAUL L *OPH
606 COURT ST STE 200
READING PA 19601-3542
215-374-5885
KRAYNACK, MD, BARRY J *AN
29 GOLDFINCH DR
WYOMISSING PA 19610-2854
215-376-4881
KRIEBEL, MD, DOROTHY E GP
232 PHEASANT RUN
LANSDALE PA 19446-5846
KRING, MD, CARROLL S GP
7 ALLISON RD
READING PA 19601-1001
KROL, MD, RONALD C PUD
1940 N 13TH ST STE 101
READING PA 19604-1543
215-929-2433
KUBACKI, MD, JOSEPH J OPH
421 S 5TH AVE
WEST READING PA 19611-1301
215-427-5058
KURJANOWICZ, MD, WADIM GP
RR 3 BOX 3205
FLEETWOOD PA 19522-9322
KUSSMAUL, MD, WILLIAM G CD
200 N 13TH ST STE 201
READING PA 19604-2955
215-375-4679
KUTSCHER, MD, HARLAN A *U
200 N 13TH ST
READING PA 19604-2961
215-372-2351
KUTZ, MD, TIMOTHY J FP
162A TREXLER AVE
KUTZTOWN PA 19530-9707
215-683-8480

LAKSHMIN, MD, MURALI *AN
COMMUNITY GENERAL HOSPITAL
READING PA 19601-3501
215-376-4881
LAMANNA, MD, JOHN V PS
40 KENHORST BLVD
READING PA 19607
215-796-1000
LAMBERT, MD, KENNETH P *GP
233 W MAIN ST
KUTZTOWN PA 19530-1603
215-683-7115
LANE, MD, C DARRELL *PTH
READING HOSP AND MED CENTER
READING PA 19612-6052
215-378-6961
LATMAN, MD, STEPHEN F ORS
2130 PENN AVE
WEST LAWN PA 19609-1600
215-670-2250
LATTIN, MD, GARY M CD
BERKS CARDIOLOGISTS LTD
READING PA 19604-2964
215-375-4679
LEASURE, MD, NICK C HEM
301 S 7TH AVE STE 220
WEST READING PA 19611-1450
215-374-4404
LEE, MD, JUNG S FP
24 N 11TH ST
READING PA 19601-3706
215-372-4200
LEE, MD, JUNG-PIL *U
318 N 5TH ST
READING PA 19601-3002
215-376-5121
LEIGHT, MD, ROBIN L OBG
717 SUMMIT CHASE DR
READING PA 19611
215-378-6000
LEINBERRY, MD, CHARLES F ORS
200 N 13TH ST STE 205
READING PA 19604-2955
215-375-8471
LEISAWITZ, MD, ELLIOTT G IM
101 W LANCASTER AVE
SHILLINGTON PA 19607-1857
215-777-6516
LEISAWITZ, MD, PAUL A GP
1817 LINDEN ST
READING PA 19604-1536
LENGEL, MD, GARY P VS
5 HEARTHSTONE CT - 105
READING PA 19606
215-779-9301
LEONI, MD, JOSEPH *U
931 PENN AVE
WYOMISSING PA 19610-3021
215-372-3555
LEVINE, MD, ALAN P IM
FLYING HILLS
READING PA 19607-3342
215-775-4500
LEVY, MD, PAUL F GE
8 N 11TH ST
READING PA 19601-3706
215-375-3962
LEWIS, MD, ELAINE R R
READING HOSPITAL & MED CENTER
WEST READING PA 19603
215-378-6108
LEWIS, MD, JOSEPH G CD
718 ROBERTS AVE
DREXEL HILL PA 19026
215-378-8413
LIGNELLI, MD, GREGORY J NS
TRI COUNTY NEUROSURGERY ASSOC
POTTSTOWN PA 19464-9208
215-327-0380
LLOYD, MD, BENJAMIN J IM
80 N MAIN BALTHASER RD
SINKING SPRING PA 19608-9455
215-378-6000
LLOYD, MD, EDGAR C *OS
MED DIR READING HOSP
READING PA 19603
215-378-6248
LODER, DO, DONALD I FP
143 E WALL ST
LEESPORT PA 19533
215-926-2123
LOEPER, MD, DONALD J FP
ROUTE 100
BALLY PA 19503
215-845-2011
LOGUE III, MD, JAMES G AN
1802 HOLLY RD
READING PA 19602
215-374-4816
LONGENECKER, MD, BENJAMIN E FP
901 ELNORE AVE
TEMPLE PA 19560-1827
LONGENECKER, MD, ROGER N FP
EAST PENN MEDICAL CENTER
BLANDON PA 19510
215-926-2166
LONGENECKER, MD, STEPHEN C ORS
1404 CLEVELAND AVE
WYOMISSING PA 19610
215-376-8671

LORD, MD, WILLIAM H FP
918 ELIZABETH AVE
READING PA 19605-2629
215-929-2762

LOUGH, MD, FREDERICK C CDS
1235 PENN AVE
WYOMISSING PA 19610-2100
215-374-5000

LOUGHEAD JR, MD, JOHN R *GYN
223 E LANCASTER AVE
SHILLINGTON PA 19607-2614
215-376-9767

LUECKE, MD, GAIL A DR
301 S 7TH AVE
READING PA 19611-1410
215-378-6108

LUSCH, MD, CHARLES J ON
301 S 7TH AVE
WEST READING PA 19611-1410
215-374-4404

LUTZ, MD, CHARLES K OTO
222 N 12TH ST
READING PA 19604-2964
215-374-5599

LYNCH, MD, JAMES D CD
59 TIMBERLINE DR
READING PA 19610-1971
215-375-6565

LYONS, MD, CLIFFORD H FP
RR 4 BOX 4221
HAMBURG PA 19526-9804
215-562-3066

MACAGY, MD, IAN D OBG
320 SUMMIT ST
WEST READING PA 19611-1133
215-378-6000

MAHMOOD, MD, EDNA Z OPH
206 S 6TH AVE
WEST READING PA 19611-1411
215-378-1344

MAIORANA, MD, S LEROY *OBG
1153 PENN AVE
WYOMISSING PA 19610-2033
215-375-4686

MALICK, MD, GERALD P *GYN
301 S 7TH AVE
WEST READING PA 19611-1410
215-375-8493

MANUBAY, MD, JOHN M FP
1510 ECKERT AVE
READING PA 19602-1401
215-378-2080

MANUBAY, MD, MARCELO A EM
1510 ECKERT AVE
READING PA 19602-1401
215-378-2330

MARCHINSKI, MD, LEONARD J ORS
301 S 7TH AVE STE 100
WEST READING PA 19611-1449
215-375-6147

MARCUS, MD, JEROME I CLP
OMEGA MEDICAL LABS
WYOMISSING PA 19610-1699
215-378-1900

MARIGLIO, MD, JOSEPH A PUD
1940 N 13TH ST STE 101
READING PA 19604-1543
215-929-2433

MARSHALL, MD, JOHN E GP
RR 1 BOX 70
RICHLAND PA 17087-9803
215-589-2555

MARTIN JR, MD, JOHN A ORS
40 LOWELL DR
READING PA 19606-9558
215-375-8471

MARTINEZ, MD, ZEFERINO ORS
640 WALNUT ST STE 303
READING PA 19601-3525
215-375-4900

MARX, MD, KENNETH W FP
401 CANDLEWOOD RD
BROOMALL PA 19008
215-378-2330

MARYNIAK, MD, GIRARD M OBG
1643 MEADOWLARK RD
READING PA 19610-2820
215-678-3240

MASSENGALE, MD, ALEXANDER T *OBG
301 S 7TH AVE STE 115
WEST READING PA 19611-1449
215-372-2800

MATHIS, MD, JAMES G AN
1905 STURBRIDGE DR
READING PA 19610-2678
215-378-6269

MATSKO, MD, JANE R FP
30 MATTHEW DR
SINKING SPRING PA 19608-9401
215-378-2000

MATTHEWS, MD, GEORGE R R
1310 MUSEUM RD
READING PA 19611-1432

MAZUZ, MD, MEIR CD
HILL RD
READING PA 19606-9804
215-375-4679

MAZZA, MD, PATRICK A FP
533 N 10TH ST
READING PA 19604-2714
215-372-8600

MCLEAN, MD, JAMES J IM
97 GRANDVIEW BLVD
WYOMISSING HILLS PA 19609-1707

MCTAMMANY, MD, J ROBERT OBG
102 TASKER AVE
SHILLINGTON PA 19607-2808
215-775-2246

MEHARG JR, MD, JOHN G *IM
39 E LANCASTER AVE
SHILLINGTON PA 19607-2631
215-777-7827

MELLON, MD, ROBERT CHP
701 E NEVERSINK RD
READING PA 19606-3209
215-779-7714

MENDELSOHN, MD, EUGENE OBG
PENNSIDE
READING PA 19606-1415
215-779-3330

MENGEL, MD, ROGER G PUD
301 S 7TH AVE STE 130
WEST READING PA 19611-1449
215-374-4421

MENGES JR, MD, JOB F *ORS
1424 PENN AVE
READING PA 19610-2134
215-374-4474

MERCURIO, MD, TERESA ON
301 S 7TH AVE
WEST READING PA 19611-1410
215-374-4404

MEYERS, MD, JOHN L EM
320 4TH ST
SHILLINGTON PA 19607-2747

MILLER, MD, JAY B U
301 S 7TH AVE STE 340
WEST READING PA 19611-1451
215-375-4579

MINEHART, MD, CHARLES R CD
222 N 12TH ST
READING PA 19604-2964
215-375-4679

MINNICH, MD, KEITH A AN
1917 STURBRIDGE DR
WYOMISSING PA 19610-2678
215-378-6269

MINTZ, MD, PAUL S *AN
READING HOSPITAL & MED CENTER
READING PA 19612-6052
215-378-5946

MITNICK, MD, PAUL D NEP
301 S 7TH AVE
WEST READING PA 19611-1410
215-376-7365

MOFFITT, MD, VINCENT J PD
1258 PENN AVE
WYOMISSING PA 19610-2130
215-374-4491

MOLL, MD, THOMAS B OPH
VAN REED PROF BLDG
WYOMISSING PA 19610-1799
215-372-0712

MONDALA-OCBO, MD, ELISA V *AN
4 SEVEN SPRINGS DR
READING PA 19607
215-378-2459

MORALES, MD, AUGUSTIN F M P FP
ST JOSEPH HOSPITAL
READING PA 19603
215-378-2000

MORGAN, MD, YVONNE G FP
ST JOSEPHS HOSP
READING PA 19603-0316

MORRIS JR, MD, VERNON R *ORS
210 N 6TH ST
READING PA 19601
215-378-1109

MORRISSEY JR, MD, E JAMES *ORS
1121 PENN AVE
WYOMISSING PA 19610-2033
215-373-5203

MORROW, MD, BERT A GS
12 MAPLE AVE
SHILLINGTON PA 19607-1216

MORSE, MD, RICHARD J PD
EXETER PEDIATRICS
READING PA 19606-9562
215-779-9550

MOSER, MD, JOHN C FP
TVMC BOX 529
MORGANTOWN PA 19543
215-286-9071

MOUFARREJ, MD, MIRNA E PD
HERSHEY MEDICAL CENTER
HERSHEY PA 17033
215-378-2080

MOY, MD, KAI H PD
130 PROSPECT ST
READING PA 19606-2866
215-779-4786

MUALLEM, MD, NABIL S *OBG
110 GAIL CIR
READING PA 19610
215-373-3738

MUHLENBERG, MD, J PETER PD
1125 BERKSHIRE BLVD STE 100
WYOMISSING PA 19610-1232
215-376-8691

MULLIGAN, MD, ROBERT L R
600 N BRIDGE ST
SHILLINGTON PA 19607-1210

NAGLE, MD, ARLINGTON A FP
RR 1 BOX 501A
WOMELSDORF PA 19567-9801

NAGY, MD, ROBERT D
150 N 11TH ST
READING PA 19601-3707
215-373-6486

NASE, MD, P KENNETH OPH
206 S 6TH AVE
WEST READING PA 19611-1411
215-378-1344

NICHOLAS JR, MD, PETER D RHU
401 BUTTONWOOD ST
WEST READING PA 19611-1101
215-375-4251

NOBLE, MD, S ROSS *PM
200 READING AVE STE 102
WEST READING PA 19611
215-478-8662

NORD, MD, D SCOTT ORS
2101 RIDGEWOOD RD STE 200
WYOMISSING PA 19610
215-375-4949

NUTTING, MD, RON D TS
324 GREENBRIAR RD
WYOMISSING PA 19610
215-374-5000

OLEWILER, MD, SCOTT D *IM
417-2 SPRINGSIDE DR E
SHILLINGTON PA 19607-1045
215-378-6000

OPLINGER, MD, ARTHUR F FP
2509 PERKIOMEN AVE
READING PA 19606-2051
215-779-2107

ORQUIZA, MD, CLODUALDO S *U
931 PENN AVE
WYOMISSING PA 19610-3021
215-372-8995

PACIULLI, MD, RAFFAELE ORS
200 N 13TH ST STE 105
READING PA 19604-2954
215-375-8471

PADIYAR, MD, RAMDAS B *AN
15 GLADWYN DR
READING PA 19606-9592
215-378-2459

PALLAS, MD, RANDOLPH S CD
1639 MEADOWLARK RD
WYOMISSING PA 19610-2820
215-375-6565

PAN, MD, EDWARD L *ORS
200 N 13TH ST STE 105
READING PA 19604-2954
215-375-8471

PAOLINI, MD, MAURO J PD
1125 BERKSHIRE BLVD STE 100
WYOMISSING PA 19610-1232
215-376-8691

PARCELLA, MD, PHYLLIS A AN
READING HOSPITAL & MED CENTER
READING PA 19611
215-378-5265

PARIKH, MD, SHIRISH N IM
73 S HAMPTON DR
WYOMISSING PA 19610-3108
215-376-4033

PATADIA, MD, CHANDRAKANT IM
2306 ALSACE RD
READING PA 19604-1115
215-372-8260

PATEL, MD, VRINDA P FP
159 VICTORIA LN
WYOMISSING PA 19610-1459

PAUL, MD, LEENA AN
200 N 13TH ST
READING PA 19604
215-378-2459

PEARAH, MD, J DAVID OPH
455 PENN AVE
SINKING SPRING PA 19608-1109
215-678-4552

PELLECCHIA, MD, DENNIS J *AN
102 ROBERT RD
WYOMISSING PA 19610
215-376-6265

PELLEGRINI, MD, VINCENT A OBG
119 GAIL CIR
WYOMISSING PA 19610-3106
215-374-2214

PENTA, MD, JOHN M OTO
301 S 7TH AVE STE 305
WEST READING PA 19611-1451
215-375-4660

PERLSTEIN, MD, MICHAEL D RHU
200 N 13TH ST STE 310
READING PA 19604-2956
215-378-1658

PERKINS, MDN, PHILIP G ORS
640 WALNUT STREET
READING PA 19601-3525
215-375-4900

PERLMUTTER, MD, GORDON S R
301 S 7TH AVE
WEST READING PA 19611-1410
215-378-6108

PEW IV, MD, JOSEPH N IM
RR 5 BOX 5081
FLEETWOOD PA 19522-9142
215-921-2366

PIEGARI, MD, GUY N CD
110 DEBORAH DR
WYOMISSING PA 19610-3104
215-375-4679

PIXLER, MD, MARY G *IM
KUTZTOWN PROF CTR
KUTZTOWN PA 19530-1640
215-683-8363

PLUCINSKY, MD, FRANCIS C *AN
403 ARROWHEAD TRL
SINKING SPRING PA 19608-9581
215-378-6269

PLYMYER, MD, RAY E A
2601 MERRITT PKY
WEST LAWN PA 19609-1029

PODOLSKY, DO, JOEL *P
244 N 5TH ST
READING PA 19601-3304
215-372-8822

POLITZER, MD, FRANK E *CD
1218 VAN STEFFY AVE
WYOMISSING PA 19610-2446
215-375-4679

POMERANTZ, MD, PHILIP A NEP
403 N 13TH ST
READING PA 19604-2822
215-375-8577

POTKONSKI, MD, LEOPOLD A P
245 ROSEDALE DR
POTTSTOWN PA 19464-4935

PROBST, MD, SUSAN J OBG
740 PENN AVE
WEST READING PA 19611-1006
215-376-3700

RAHMANIAN, MD, NADER *IM
3625 STOUDTS FERRY BRIDGE RD
READING PA 19605-1444
215-376-3936

RAMSEY JR, MD, HARRY E HEM
301 S 7TH AVE
WEST READING PA 19611-1410
215-374-4404

REBER, MD, HOWARD F U
1310 E WYOMISSING BLVD
READING PA 19611-1750

REED, MD, CLIFFORD A *N
301 S 7TH AVE
WEST READING PA 19611-1410
215-372-0813

REED, MD, MARK S CLP
333 WHEATLAND AVE
SHILLINGTON PA 19607-1370

REES, MD, DAVID B ORS
401 BUTTONWOOD ST
WEST READING PA 19611-1101
215-376-8671

REHR, MD, ROGER B CD
122 LEISURE CT
WYOMISSING PA 19610-1903
215-375-6565

REICHARD, MD, RICHARD C *GP
112 S HOME AVE PO BOX 68
TOPTON PA 19562
215-682-2160

REIFSNYDER, MD, WILLIAM H *IM
560 VAN REED RD STE 101
WYOMISSING PA 19610-1799
215-378-1601

REIGH, MD, ERNEST E NS
RR 3 BOX 3995
MOHNTON PA 19540-9271

REILEY, DO, MARGARET A PD
1258 PENN AVE
WYOMISSING PA 19610
215-374-4491

REINER, MD, REBECCA L PD
1258 PENN AVE
WYOMISSING PA 19610
215-374-4491

REINSEL, MD, RICHARD C GS
1314 MONROE AVE
WYOMISSING PA 19610-2434

RENKERT, MD, ELIZABETH E FP
E MAIN ST
MORGANTOWN PA 19543
215-286-9064

RESTREPO, MD, JAMES P *OTO
222 N 12TH ST
READING PA 19604-2964
215-374-5599

REUBEN, MD, MARK S PD
40 BERKSHIRE CT
WYOMISSING PA 19610-1224
215-374-7400

RIGHTMYER, MD, JOHN N FP
15 SCENIC DR
HAMBURG PA 19526

RIGHTS, MD, THEODORE H GP
1164 N 13TH ST
READING PA 19604-2116
215-375-8445

ROBERTSON, MD, JOHN J *GP
30 E MAIN ST
KUTZTOWN PA 19530-1513
215-683-7393

ROBINSON, MD, MICHAEL L DR
80 DOWNING DR
WYOMISSING PA 19610-3109
215-378-6108

RODRIGUEZ, MD, ADOLFO E GS
301 S 7TH AVE STE 230
WEST READING PA 19611-1450
215-375-4381

ROGERS JR, MD, ROBERT M OBG
WOMENS CLINIC
WEST READING PA 19611
412-374-2214

ROSENZWEIG, MD, BETH E GE
301 S 7TH AVE STE 215
WEST READING PA 19611-1450
215-374-4401

ROTENBERG, MD, LARRY A P
560 VAN REED RD STE 301
WYOMISSING PA 19610-1799
215-378-9601

ROWAN, MD, NOEL M *IM
1661 GARFIELD AVE
WYOMISSING PA 19610-2351
215-376-8004

ROWAN, MD, SANDRA K PD
310 N 11TH ST
READING PA 19604-2904
215-373-1605

ROZANSKI, MD, STANLEY J FP
941 FRANKLIN ST
READING PA 19602-1751
215-374-9624

RUBRIGHT, MD, GEORGE L GP
600 FAIRMONT AVE
WERNERSVILLE PA 19565-9756

RUDOLPH, MD, ROBERT I D
1134 PENN AVE
WYOMISSING PA 19610-2034
215-374-4463

RUNYEON, MD, WILLIAM K GS
301 S 7TH AVE STE 375
WEST READING PA 19611-1436
215-478-1900

SACKS, MD, DAVID R
READING HOSP DEPT RADIOLOGY
READING PA 19612
215-378-6108

SAHOO, MD, KASHINATH *TR
ST JOSEPHS HOSPITAL
READING PA 19603
215-378-2117

SALILENG, MD, FILEMON F FP
211 TAFT AVE
READING PA 19605-2123
215-378-2080

SANTORO, MD, WILLIAM FP
3212 KUTZTOWN RD
READING PA 19605
215-929-3380

SCHAEBLER, MD, M LEE FP
7 CORNELL AVE
WEST LAWN PA 19609-2318
215-777-2643

SCHARTEL, DO, ALBERT P GP
451 DOUGLASS ST
READING PA 19601-2545
215-372-1614

SCHWARTZ, MD, PETER A *OBG
READING HOSPITAL & MED.CENTER
READING PA 19617-6502
215-278-6827

SCHWEIZER, MD, ROBERT R *FP
137 E PENN AVE
ROBESONIA PA 19551-1527
215-693-5831

SCORNAVACCHI, MD, JOSEPH M U
111 CLUBHOUSE DR
BERNVILLE PA 19506-9536

SCORNAVACCHI JR, MD, JOSEPH M ORS
401 BUTTONWOOD ST
WEST READING PA 19611-1101
215-376-8671

SCOVERN, MD, HENRY AI
2001 BERN RD
WYOMISSING PA 19610
215-478-1737

SCULLY, MD, JOHN P D
1219 WEAVERTOWN RD
DOUGLASSVILLE PA 19518

SEDA, MD, HECTOR J HNS
301 S 7TH AVE
WEST READING PA 19611-1410
215-376-9728

SEO, MD, JIN S AN
BERKS ANESTHESIA ASSOC INC
READING PA 19604-2991
215-378-2459

SERGI, MD, MICHAEL A PD
40 BERKSHIRE CT
READING PA 19610
215-374-7400

SESSLER, MD, MONIQUE N FP
READING HOSPITAL AND MED CTR
READING PA 19612-6052
215-378-6198

SEXTON JR, MD, GEORGE L GYN
301 S 7TH AVE
WEST READING PA 19611-1410
215-374-2214

SHADDUCK, MD, SNEED P AN
READING HOSPITAL & MED CENTER
READING PA 19603
215-378-6269

SHAFFER, MD, EUGENE M GS
301 S 7TH AVE STE 310
WEST READING PA 19611-1451
215-378-7900

SHAFFER, MD, IRVIN G *AN
2200 LORRAINE RD
READING PA 19604-1304

SHAH, MD, HARNISH V PD
501 WARWICK DR
READING PA 19610-1825
215-921-1111

SHAPIRO, MD, JOHN A PUD
301 S 7TH AVE STE 130
WEST READING PA 19611-1449
215-374-4421

SHAPIRO, MD, TIMOTHY A CD
501 MARY WATERSFORD RD
BALA CYNWYD PA 19004
215-378-8413

SHEFFER, MD, M LEONARD GP
RR 3 BOX 317
BIRDSBORO PA 19508-9803
215-582-2848

SHELBY, MD, JOHN H OTO
301 S 7TH AVE STE 305
WEST READING PA 19611-1451
215-376-6990

SHEMANSKI, MD, CLEM J GER
FLYING HILLS
READING PA 19607-3304

SHULTZ, MD, BARRY S U
301 S 7TH AVE STE 340
WEST READING PA 19611-1451
215-375-4579

SHUMAN, MD, JOHN F PUD
301 S 7TH AVE STE 130
WEST READING PA 19611-1449
215-374-4421

SHUMAN, MD, NANCY A IM
301 S 7TH AVE STE 130
WEST READING PA 19611-1449
215-374-4422

SILVERBERG, MD, ROBERT L FP
WYOMISSING VALLEY MEDICAL
MOHNTON PA 19540-1812
215-775-3710

SILVERMAN, MD, EDWARD J * IM
600 MUSEUM RD
READING PA 19611
215-375-0260

SLAVISH, MD, LYDIA G OBG
1340 PENN AVE
WYOMISSING PA 19610-2132
215-375-4241

SMITH, MD, BARTON L * GS
301 S 7TH AVE
WEST READING PA 19611-1410
215-374-4401

SMITH, MD, RAYMOND L * PS
926 PENN AVE
WYOMISSING PA 19610-3017
215-372-2130

SMITH, MD, RONALD E AN
960 WAYNE AVE
WYOMISSING PA 19610-2272
215-376-0269

SMOKER, MD, CYNTHIA B FP
48 N DUKE ST
MILLERSVILLE PA 17551-1602
215-378-6000

SOUDERS, MD, THOMAS B OPH
VAN REED PROF BLDG
WYOMISSING PA 19610-1799
215-372-0712

STAEBLER, MD, ROBIN J * FP
2948 ST LAWRENCE AVE
READING PA 19606-2233
215-779-9438

STANTON, MD, ELIZABETH L FP
412 SYCAMORE RD
WEST READING PA 19611
215-376-6695

STEIN, MD, WALTER * AN
PO BOX 6109
WYOMISSING PA 19610-0109
215-376-4881

STELMACH, MD, PETER IM
1500 OAK LN
READING PA 19604-1505
215-373-7833

STELMACH, MD, W PETER FP
1500 OAK LN
READING PA 19604-1505
215-373-7833

STOLZ, MD, JOHN C R
THE HIGHLANDS
READING PA 19610-2714

STOLZ, MD, JONATHAN L * R
COMMUNITY GENERAL HOSPITAL
READING PA 19601-3501
215-378-8355

STOLZ, MD, PAUL K R
BOX 39 SHEEP HILL RD
FLEETWOOD PA 19522

STOUDT, MD, DONALD E N
801 SLEDGE AVE
READING PA 19609-1112

STOUDT, DO, KATHY J * FP
711 N 5TH ST
READING PA 19601-2209
215-376-7645

STRAUSE JR, MD, HAROLD L OPH
250 LEVAN ST
READING PA 19606

STROBEL JR, MD, GEORGE E * AN
RR 1 BOX 106
WERNERSVILLE PA 19565-9722
215-378-6265

SUMMONS, MD, HOWARD J * U
RR 6 BOX 203
SINKING SPRING PA 19608-9808

SUTHERLAND, MD, ROBERT D ORS
401 BUTTONWOOD ST
WEST READING PA 19611-1101
215-376-8671

SWEET, MD, WILLIAM A GS
301 S 7TH AVE
WEST READING PA 19611-1410
215-374-4055

SZARKO, MD, CAROL J AN
RR 1 BOX 200
OLEY PA 19547-9801
215-378-6269

SZARKO, MD, FRANK J TR
READING HOSPITAL & MED CENTER
READING PA 19603
215-378-6067

TALLMAN, MD, EDWIN H GP
RR 3 BOX 126
OLEY PA 19547-9734

TASE, MD, DOUGLAS S ORS
200 N 13TH ST STE 105
READING PA 19604-2954
215-375-8471

THOMAS JR, MD, ROBERT F GS
301 S 7TH AVE STE 375
WEST READING PA 19611-1436
215-478-1900

TIETBOHL, MD, RALPH H FP
25 STEVENS AVE
WEST LAWN PA 19609-1400
215-678-2266

TOSO, MD, GIANFRANCO F OTO
301 S 7TH AVE
WEST READING PA 19611-1410
215-376-9728

TREXLER, MD, ETHAN L FP
PO BOX 106
FLEETWOOD PA 19522-0106

TRONCALE, MD, JOSEPH A FP
ST JOSEPH FAMILY PRACTICE
READING PA 19604
215-378-2080

TRUEX JR, MD, RAYMOND C NS
601 SPRUCE ST
WEST READING PA 19611
215-375-4567

TURNER, MD, RONALD L FP
200 N 13TH ST STE 100
READING PA 19604
215-378-2080

VALENCIA, MD, CELEDONIO C EM
357 PENNSYLVANIA AVE
SHILLINGTON PA 19607-1313

VENIER, MD, LEON H PM
200 N 13TH ST STE 300
READING PA 19604-2958
215-372-5198

VILLARS, MD, FREDERICK CDS
1235 PENN AVENUE
WYOMISSING PA 19610
215-374-5000

WADEMAN, MD, ROSS L GS
301 S 7TH AVE
WEST READING PA 19611-1410
215-373-4151

WAGNER, MD, JOHN B FP
600 MUSEUM RD
READING PA 19611
215-376-1340

WANCZYK, MD, CASIMIR J OBG
4550 OLEY TURNPIKE RD
READING PA 19606-9574
215-374-0970

WEAVER, MD, KENT E FP
2509 PERKIOMEN AVE
READING PA 19606-2051
215-779-2107

WEAVER, MD, M FAY * GP
COMMUNITY HEALTH CTR
READING PA 19601-3307
215-378-8364

WEIDMAN, EXEC DIR, BRUCE R
1940 N 13TH ST STE 248
READING PA 19604-1544
215-929-8853

WEIDNER, MD, SANDRA L PD
31A GULF STREAM DR
READING PA 19607
215-770-9111

WEISBERG, MD, JEROME S RHU
401 BUTTONWOOD ST
WEST READING PA 19611-1101
215-375-4251

WELSH, MD, JAMES F PTH
RR 4 BOX 4846
MOHNTONPA 19540-9710

WEST JR, MD, WILLIAM J * OBG
111 LUCINDA LANE
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DOYLESTOWN PA 18901
215-345-6090
BARNES, MD, DENICE M PD
370 MIDDLETOWN BLVD
LANGHORNE PA 19047-1822
215-741-0336
BARONE, MD, FRANCES A PD
131 S 11TH ST
QUAKERTOWN PA 18951-1547
215-536-2555
BARRER, MD, MITCHELL J AN
700 LAWN AVE
SELLERSVILLE PA 18960-1548
BARRIS, MD, BRUCE J IM
8100 BROCKSIDE RD
PHILADELPHIA PA 19117-2402
215-946-1500
BARTOLANZO, MD, ROBERT A * PD
483 OLIVE ST
PITTSBURGH PA 15237-4886
412-771-6462
BASEMAN, MD, ALAN S FP
164 MAIN ST
SILVERDALE PA 18962
215-257-7550
BEDDINGS, MD, ALEJANDRO * PS
1205 LANGHORNE-NEWTOWN RD 206
LANGHORNE PA 19047
215-757-8430
BELOFF, MD, LOUIS GP
BEAVER HILL CONDO UNIT 424
JENKINTOWN PA 19046
215-674-1372
BENJAMIN, MD, JOSEPH NEP
130 CLEAR CREEK RD
LANGHORNE PA 19047-1336
BENSON, MD, JOHN M DR
1487 BILO RD
YARDLEY PA 19060
609-393-0333
BERK, MD, ROBERT L OBG
114 BRUCE RD
WASHINGTON XING PA 18977
BERNAL, MD, GUILLERMO J PM
613 E MELISSA CIR
YARDLEY PA 19067
215-752-0900
BERNARDINO JR, MD,
VITALIANO B OPH
ST MARY MEDICAL BLDG # 211
LANGHORNE PA 19047
215-752-7194
BERNSTEIN, DO, HENRY H PD
711 LAWN AVE
SELLERSVILLE PA 18960-1575
215-257-2727
BERNSTEIN, MD, MARK H * P
505 BETHLEHEM PIKE STE 4
MONTGOMERYVILLE PA 18936-9709
215-822-2224
BIUCKIANS, MD, EDWARD P
1517 DURHAM RD
PENNDEL PA 19047-5707
215-752-1541
BLACKBURN JR, MD,
LAURENCE H OM
22 WATER CREST DR
DOYLESTOWN PA 18901-3240
215-345-5650
BLOCK, MD, STEVEN OBG
920 LAWN AVE
SELLERSVILLE PA 18960-1560
215-257-1193
BLOOM, MD, SANDRA L * P
1110 N WEST END BLVD
QUAKERTOWN PA 18951-1192
215-536-2636
BLORE JR, MD, JAMES P FP
GENERAL DELIVERY
PLUMSTEADVILLE PA 18949-9999
215-766-8849
BOLAND JR, MD, FRANCIS B ORS
140 MEMORIAL DR
DOYLESTOWN PA 18901
BOLANOWSKI, MD, DEBORAH J PD
105 PENN AVE
TELFORD PA 18969
215-723-7177
BONNER, MD, DENNIS J PM
1667 WRIGHTSTOWN RD
NEWTOWN PA 18940-2815
215-752-0200
BONNER, MD, WILLIAM F PM
333 N OXFORD VALLEY RD
FAIRLESS HILLS PA 19030-2618
215-547-8611
BORAH, MD, BISHNU C * PD
380 MIDDLETOWN BLVD # 702
LANGHORNE PA 19047-1822
215-752-9100
BRACKIN, MD, GEORGE G R
DOYLESTOWN HOSPITAL
DOYLESTOWN PA 18901-2597
215-345-2290
BRECHER, MD, JEFFREY A * IM
225 NEWTOWN RD STE K
WARMINSTER PA 18974-5251
BRENNEMAN, MD, PAUL G FP
365 IRON HILL RD
DOYLESTOWN PA 18901
BRESLIN, MD, KENNETH S IM
301 OXFORD VALLEY RD STE 701
YARDLEY PA 19067
215-321-7221
BRODIE, MD, DONALD E FP
706 BRIARWOOD CT
YARDLEY PA 19067-3005
609-562-3346
BROWN JR, MD, WILLIAM C OPH
38 BAILEY DR
WSHNGTN CRSNG PA 18977-1010
215-860-0909
BROWN V, MD, THOMAS W GS
750 S WEST END BLVD
QUAKERTOWN PA 18951-2662
BRYAN JR, MD, JOHN S ORS
800 W STATE ST
DOYLESTOWN PA 18901-2250
215-348-3541
BUCHER, MD, ROBERT G GP
CHERRY LN
WYCOMBE PA 18980
215-598-3621
BUCKLER, MD, RICHARD A N
920 LAWN AVE
SELLERSVILLE PA 18960-1560
215-257-4900
BUCKWALTER, MD, JEFFREY A FPS
14 SANDY KNOLL DR
DOYLESTOWN PA 18901-2425
215-348-1152
BULKLEY, MD, ANDREW D EM
7893 S CAMINO LORCA
GREEN VALLEY AZ 85614-1214
BUMGARDNER, MD, JAMES L * ORS
LAWN AVE PROF CTR
SELLERSVILLE PA 18960
215-257-3789
BURKE, MD, JEROME M * GE
836 LAWN AVE
SELLERSVILLE PA 18960
215-257-5071
BURMEISTER, MD, CHARLES W * GP
PLUMSTEADVILLE PA 18949
BYER, MD, HAROLD H OPH
5045 SWAMP RD STE 101
FOUNTAINVILLE PA 18923
215-348-0443
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127 S 5TH ST STE 170
QUAKERTOWN PA 18951-1666
215-536-3888
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300 MIDDLETOWN BLVD STE 100
LANGHORNE PA 19047-1822
215-547-2670
CANDIA, MD, ANDREA J DR
DOYLESTOWN HOSPITAL
DOYLESTOWN PA 18901
215-345-2289
CAPPIELLO, MD, WILLIAM A GS
57 RUST HILL RD
LEVITTOWN PA 19056-2311
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444 S STATE ST STE C3
NEWTOWN PA 18940-1945
215-860-8100
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BRISTOL PA 19007-5406
215-788-5594
CARVAJAL, MD, ROBERTO T IM
2105 YARDLEY RD
YARDLEY PA 19067-3065
215-752-4110
CASALE, MD, LOUIS J PD
757 W BANDY RIDGE RD
DOYLESTOWN PA 18901-2129
215-471-2761
CAUFFMAN, MD, WILLIAM J IM
1723 WOODBOURNE RD
LEVITTOWN PA 19057-5303
CEVALLOS, MD, EDUARDO A PD
541 S WEST END BLVD
QUAKERTOWN PA 18951-1407
CHAI, MD, CHIU L FP
256 TRUMBAUERSVILLE RD
QUAKERTOWN PA 18951-2651
215-536-0655
CHARNEY, MD, RICHARD H * U
205 NEWTOWN RD STE 101
WARMINSTER PA 18974-5206
215-674-0301
CHAWLA, MD, HARISH C GS
1411 WOODBOURNE RD
LEVITTOWN PA 19057-1504
215-943-2000
CHIN, MD, BYOUNG KWON IM
763 GROVE AVE
SOUTHAMPTON PA 18966-3438
CHIRAYATH, MD, MERCY IM
165 CHESTVIEW WAY
YARDLEY PA 19067
CHOBY, MD, JOHN J OBG
83 FOXCROFT DR
DOYLESTOWN PA 18901-3263
215-340-2229
CIANFRANI, MD, PETER M FP
825 MAIN ST
PENNSBURG PA 18073-1631
215-679-4421
CICCOTELLI, MD, ALDO A FP
118 W RICHARDSON AVE
LANGHORNE PA 19047
717-385-1598
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FLOURTOWN COMMONS STE 213
FLOURTOWN PA 19031-1111
215-233-2810
CLARKE, MD, FRANKLYN R P
376 S BELLEVUE AVE
LANGHORNE PA 19047-2808
215-757-3030
CLIPP, MD, SAMUEL W R
500 INDEPENDENCE DR
HARLEYSVILLE PA 19438-3960
215-453-4483
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609-393-0333
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400 WESTVIEW RD
ELKINS PARK PA 19117-2427
215-355-3525
COLETTA, MD, DANIEL J OBG
730 SPRING VALLEY RD
DOYLESTOWN PA 18901-3256
215-348-3362
CONAHAN, MD, BERNARDIN Q PD
327 DORSET CT
DOYLESTOWN PA 18901-2500
CONCOOL, MD, BARRY M OPH
WOODBOURNE EYE CTR
LEVITTOWN PA 19057-1597
215-943-7800
CONNORS JR, MD, EARL K FP
ST MARY HOSPITAL
LANGHORNE PA 19047-1295
215-750-2000
CONRAD, MD, JAMES L GP
1301 N 5TH ST
PERKASIE PA 18944-2256
215-257-5128
COOK, MD, RICHARD P FP
425 RACT ST
PERKASIE PA 18944
215-257-3792
COSENTINO, MD, MARK O DR
16 LAFAYETTE DR
CLEMENTON NJ 08021
215-648-5000
COSTANTINO, MD, GEORGE N * GS
402 MIDDLETOWN BLVD STE 214
LANGHORNE PA 19047-1822
215-750-1511
COVERDALE, MD, PAUL J IM
BURNT HOUSE HILL RD
DOYLESTOWN PA 18901
COVERDALE III, MD, EDWARD J IM
RR 2 WATSON DR
DOYLESTOWN PA 18901-9802
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THE LANDMARK BLDG 3RD FLR
DOYLESTOWN PA 18901
215-348-5717
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602 STRATFORD CT
LANSDALE PA 19446-6379
215-453-4815
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215-355-1155
CURCI, MD, JOSEPH J GS
18 GOLFVIEW RD
DOYLESTOWN PA 18901
215-348-7080
D'AMBROSIO, DO, ROBERT P FP
7401 SOCIETY DR
CLAYMONT DE 19703
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920 LAWN AVE
SELLERSVILLE PA 18960-1560
215-257-4900
DANZIS, DO, JEFFREY J FP
202 N MAIN ST
CHALFONT PA 18914-2916
215-822-3113
DARNELL, MD, RICHARD I GP
GREENHOUSE PLZ VILLAGE II
NEW HOPE PA 18938
215-862-2800
DAVIES, MD, ROBERT J IM
1723 WOODBOURNE RD STE 1
LEVITTOWN PA 19057
215-945-1650
DAVIS, MD, HARRIET J PDA
PENNSWOOD VILLAGE C113
NEWTOWN PA 18940
DEGROOF, MD, ELLEN P L * AN
145 WATER CREST DR
DOYLESTOWN PA 18901-3267
215-257-3611
DELVECCHIO, MD, FREDESUINDA P GP
2392 DIXON AVE
CROYDON PA 19021-5123
DEPENA, MD, CHARLES A N
700 LAWN AVE
SELLERSVILLE PA 18960-1548
215-453-4000
DERRICK, MD, BRUCE M GS
16 N FRANKLIN ST
DOYLESTOWN PA 18901-3536
215-348-7080
DERSHAW, MD, BRUCE B PUD
333 N OXFORD VALLEY RD #510
FAIRLESS HILLS PA 19030-2618
DESANTIS, MD, LUIGI IM
97 W TRENTON AVE
MORRISVILLE PA 19067-6651
215-295-7012
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200 APPLE ST STE 3
QUAKERTOWN PA 18951-1657
215-536-8665
DEVENUTO JR, MD, JOSEPH J OPH
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215-345-6100
DEVINE, MD, PETER J OM
6 PHEASANT DR
HOLLAND PA 18966-1949
DIMOIA, MD, MARGARET M PD
301 FAIRVIEW AVE
LANGHORNE PA 19047-5113
215-752-8433
DIPIETRO, MD, DAVID E FP
109 VICTORIA LN
HORSHAM PA 19044-1243
215-794-7471
DIRIENZO, MD, ENRICO J * FP
833 DURHAM RD
PENNDEL PA 19047-5736
717-752-5433
DOBROTA, MD, JOHN S GE
UB MEDICAL ARTS BLDG
SELLERSVILLE PA 18960-1549
215-257-5071
DOWNS, DO, CAROLYN R FP
119 CHAPEL RD
NEW HOPE PA 18938-1007
215-427-7287
DRAGANOSKY, MD, EUGENE A * OBG
1288 NEW RODGERS RD
LEVITTOWN PA 19056-1601
215-757-8200
DREZNER, MD, MALCOLM E GS
6 BARCLAY CT
NEWTOWN PA 18940-1555
DSILVA, MD, HENRY I IM
274 ANDREW DR
NEWTOWN PA 18940-2221
215-579—225
DUFFIELD, MD, THOMAS E FP
201-B MAKEFIELD EXEC QUARTERS
YARDLEY PA 19067
215-493-1033
DYCKMAN, MD, SHARON OPH
48 LANFAIR RD
CHELTENHAM PA 19012-1422
215-925-5428
EBERHART, MD, JOSEPH C FP
824 DUCHESS DR
YARDLEY PA 19067-4620
215-493-5535
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142 BELLEVUE AVE BOX 173
PENNDEL PA 19047-5256
EHMANN, MD, CARL W D
JOHNSON AND JOHNSON BABY
PROD
SKILLMAN NJ 08558
201-874-1380
EICHER, MD, WENDELL P GS
750 S WEST END BLVD
QUAKERTOWN PA 18951-2662
215-536-1133
EILERS, MD, STEVEN G P
301 OXFORD VALLEY RD STE 603A
YARDLEY PA 19067-6345
215-493-2400

EPSTEIN, MD, KENNETH R IM
169 MEADOW VIEW CT
LANGHORNE PA 19047
ERLICHMAN, MD, I FULTON IM
2 SHADYWOOD RD
LEVITTOWN PA 19056-1706
ESCHBACH, MD, EUGENIE M P
807 LAWN AVE
SELLERSVILLE PA 18960
215-257-6551
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420 SAVANNAH TRACE
CLARKSVILLE TN 37043
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711 LAWN AVE
SELLERSVILLE PA 18960-1583
215-257-2727
FALCO, MD, FRANK G IM
5105 LANDISVILLE RD
DOYLESTOWN PA 18901-1224
215-345-0805
FANELLI, DO, ANDREW T * GE
THE COURTYARD AT OXFORD VLY
LANGHORNE PA 19047-1822
215-750-7117
FASS, MD, BARRY D OS
325 E STREET RD
FEASTERVILLE PA 19053-7711
215-322-2777
FAST, MD, WILLIS B GS
157 WILLOW DR
LEVITTOWN PA 19054-3116
FERRARA, MD, JOSEPH D FP
GENERAL DELIVERY
PLUMSTEADVILLE PA 18949-9999
215-766-8844
FERRY, MD, JANE A EM
GRANDVIEW HOSPITAL
SELLERSVILLE PA 18960-1581
215-453-4200
FERRY, MD, NICHOLAS J GP
238 WILLOW DR
LEVITTOWN PA 19054-3119
215-943-3333
FIELDS, MD, RONALD H CD
253 EMERALD DR
YARDLEY PA 19067-5740
215-750-7818
FILIPOWICZ, MD, THOMAS A EM
704 REMINGTON CT
CHALFONT PA 18914
215-538-4580
FINKELSTEIN, MD, GARY S GS
PO BOX 330
SELLERSVILLE PA 18960-0330
215-257-3697
FINLEY, MD, JOHN G R
440 LAWRENCE RD
HUNTINGDON VLY PA 19006-2335
215-750-2279
FLACCO, MD, ALBERT J PD
OXFORD BO STE 502
LANGHORNE PA 19047-1822
215-741-0336
FLASHNER, MD, STEVEN C U
377 BIRDSONG WAY
DOYLESTOWN PA 18901
215-230-0600
FODERARO, MD, ANTHONY E DR
GRANDVIEW HOSPITAL
SELLERSVILLE PA 18960
215-453-4511
FORD, MD, FRANCIS W GS
FRANKLIN AND WOOD ST
DOYLESTOWN PA 18901
215-348-7080
FORSTER, MD, TERRENCE J RHU
PO BOX 365
PT PLEASANT PA 18950-9999
215-340-1880
FRANKLIN, MD, IRVIN D GS
205 NEWTOWN RD STE 215
WARMINSTER PA 18974-5207
FREDRICKSON, MD, VICTOR J GP
VILLAGE II 48 DARIEN
NEW HOPE PA 18938-1260
FREED, MD, CLARENCE L * PS
870 LAWN AVE
SELLERSVILLE PA 18960-1571
215-257-6506
FRIEDBERG, MD, JAY G OPH
172 MIDDLETOWN BLVD STE 208
LANGHORNE PA 19047-1822
215-752-3511
FRIEDMAN, MD, IRWIN OBG
820 TOWN CTR DR STE 125
LANGHORNE PA 19047-1748
215-752-1733
FRIEDMAN, MD, PHILLIP * GP
131 S BELLEVUE AVE
LANGHORNE PA 19047-2803
215-757-4334
GALIETTA, MD, MARYANN C GER
PO BOX 823
YARDLEY PA 19067-0623
215-493-0556
GALLAGHER, MD, JOHN T OTO
275E W STREET RD
FEASTERVILLE PA 19053-4116
215-355-1155

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309 E WASHINGTON AVE
NEWTOWN PA 18940-2127
215-968-2346
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18 FAIRVIEW RD
MEDFORD NJ 08055
609-795-3333
GASTON, MD, NOREEM M * IM
1112 TAYLORSVILLE RD
WASHINGTON XING PA 18977
215-493-8080
GAUL, MD, JAMES J * N
BARNBROOK FARM
NEWTOWN PA 18940-1307
GEETTER, MD, PHILIP H OPH
711 LAWN AVE
SELLERSVILLE PA 18960-1575
215-257-8053
GHAHRAMANI, MD, MAHMOOD P
35 DURAND RD
HUNTINGDON VLY PA 19006-7915
215-676-8404
GIRONE, MD, JOSEPH A C * PD
711 LAWN AVE
SELLERSVILLE PA 18960-1575
215-257-2727
GITTLEN, MD, STANFORD D PUD
800 W STATE ST STE 204
DOYLESTOWN PA 18901-2250
215-348-1310
GODSHALL, MD, RICHARD W * ORS
PROF CENTER
SELLERSVILLE PA 18960
215-257-3700
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401 RADCLIFFE ST
BRISTOL PA 19007-5126
215-785-6531
GOLDBERG, MD, MICHAEL E * AN
80 POST RD
CHURCHVILLE PA 18966-1160
609-393-8838
GOLDFARB, MD, RICHARD M * GS
15 PARTRIDGE CT
NEWTOWN PA 18940-1853
215-741-4321
GOLDSTEIN, MD, ARNOLD L IM
17 MIDDLETOWN BLVD STE 101
LANGHORNE PA 19047-1822
215-757-8100
GOLDSTEIN, MD, RICHARD S * CRS
390 MIDDLETOWN BLVD STE 612
LANGHORNE PA 19047-1822
215-741-4910
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1321 NE 41ST ST
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GOODMAN, MD, BRUCE A IM
1370 APPLE BLOSSOM DR
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215-757-8100
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205 NEWTOWN RD STE 213
WARMINSTER PA 18974-5207
215-674-0133
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370 MIDDLETOWN BLVD STE 504
LANGHORNE PA 19057
215-750-0315
GREEN, MD, BRADFORD * OBG
ROYAL OAK MD 21662
GREENBAUM, MD, ROY L DR
43 POLDER DR
LANGHORNE PA 19053-1521
GREENSPAN, MD, MITCHELL M * CD
3 LIFEMARK DR
SELLERSVILLE PA 18960
215-248-1127
GRIBB, MD, JOHN J * OBG
14A MEMORIAL DR
DOYLESTOWN PA 18901-3511
GRIFFITH, MD, ANNETTE Y DR
ABINGTON MEMORIAL HOSPITAL
ABINGTON PA 19001-3707
215-947-7851
GUAGLIARDO, DO, JOSEPH P * ORS
253 W STATE ST
DOYLESTOWN PA 18901-3531
215-348-0222
GUPTA, MD, NAND K GP
3616 CLEAR SPRINGS DR
BENSALEM PA 19020-4702
215-638-7363
GUTTMAN, MD, MICHAEL IM
2783 MECHANICSVILLE RD
BENSALEM PA 19020-2626
215-752-5501
HAAS, DO, GLENN E VS
74 MISTY MEADOW DR
RICHBORO PA 18954-1643
215-295-6222
HAIMOWITZ, MD, DANIEL IM
1 GARDENIA RD
LEVITTOWN PA 19057-3411
215-943-2222
HALE, MD, ROBERT H IM
148 MEMORIAL DR
DOYLESTOWN PA 18901-3511
215-345-6050

HALPERN, MD, JANIS S PD
530 ATKINSON LN
LANGHORNE PA 19047-1460
215-752-8700
HANNUSH, MD, SADEER S OPH
919 DURHAM RD
PENNDEL PA 19047-5738
215-752-8564
HANSEN, MD, CARL A ORS
711 LAWN AVE PROF CTR
SELLERSVILLE PA 18960
215-257-3700
HARDY, MD, CHARLES A AN
562 GAINSWAY RD
YARDLEY PA 19067-3009
HARR, MD, DOUGLAS P IM
836 LAWN AVE
SELLERSVILLE PA 18960-1550
215-257-3011
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DOYLESTOWN PA 18901
215-348-7080
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1244 FT WASHINGTON AVE
FT WASHINGTON PA 19034
215-646-0200
HARTENBAUM, MD, NATALIE T OM
152 BATEMAN RD
LANGHORNE PA 19047-1407
215-750-5482
HASIUK, MD, AARON S * OBG
1310 FROSTY HOLLOWS RD
LEVITTOWN PA 19056
215-943-3300
HAYMAN, MD, HARRY B OBG
81 CRABTREE DR
LEVITTOWN PA 19055-1617
215-946-2882
HEDRICK, MD, G WINFIELD FP
20 S SCHOOL LN
BOUDERTON PA 18964-1227
HELZNER, MD, EILEEN C GP
505 ANTHONY DR
PLYMOUTH MTNG PA 19462-1043
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301 S MAIN ST STE 2
DOYLESTOWN PA 18901-4870
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1 SUGARMAPLE LN
LEVITTOWN PA 19055-2007
215-945-8500
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1 SUGARMAPLE LN
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215-945-8500
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215-348-1310
HORWITZ, MD, MILTON R OTO
103 PROGRESS DR
DOYLESTOWN PA 18901
215-348-1152
HOUGAARD, MD, JOHN P GP
800 TRENTON RD APT 93
LANGHORNE PA 19047-5848
HOUGH, MD, DOUGLAS R RHU
437 MUSKET DR
MORRISVILLE PA 19067-4908
215-428-5700
HOWELL, MD, JOHN T FP
82 S MAIN ST
YARDLEY PA 19067-0404
215-493-5535
HUNT, MD, EUGENE H DR
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DOYLESTOWN PA 18901
215-345-2174
HUNTER, MD, MARVIN T PS
PLASTIC SURGERY ASSOC
WARMINSTER PA 18974-5206
215-672-0700
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MORRISVILLE PA 19067
609-599-5000

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6445 MAPLE HILL LN
COOPERSBURG PA 18036
215-453-4514
HYLAND, MD, JULIA K PD
148 PENNS GRANT DR
MORRISVILLE PA 19067-4917
IANNI, DO, BARBARA D NPM
1128 NEWPORT MEWS DR
BENSALEM PA 19020
215-590-1000
IANNI, DO, DANIEL J ORS
1128 NEWPORT MEWS DR
BENSALEM PA 19020-3949
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55 KIRKWOOD DR
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DEVON PA 19333-1820

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29 MANCHESTER CT
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20 DOGWOOD HILL LN
CHADDS FORD PA 19317-9106
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57 MARLYN LN
EXTON PA 19341-1667
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461 ROBINWOOD LN
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PHOENIXVILLE PA 19460-4444
215-983-3700
KORBONITS, MD, CHARLES W * OBG
960 HILLSDALE RD
WEST CHESTER PA 19382-1921
215-696-4130
KOVALSKI, MD, RAYMOND PUD
750 S MAIN ST STE 100
PHOENIXVILLE PA 19460-4444
215-933-8484
KRAUS, MD, JOHN J PM
BRYN MAWR REHABILITATION HOSP
MALVERN PA 19355-3300
215-251-5690
KRAUSER, MD, RONALD E RHU
154 THREE PONDS LN
MALVERN PA 19355
215-647-2398
KRIPKE, MD, SCOTT A GS
PAOLI MEDICAL BLDG STE 327
PAOLI PA 19301
215-647-3077
KRISHNA, MD, BHUPENDRA A
LONGWOOD RD
KENNETT SQUARE PA 19348
215-869-8737
KRISHNA, MD, NARENDRA OPH
1102 N NEW ST
WEST CHESTER PA 19380-3838
KRISHNAN, MD, SHANTI PD
634 W ROLLING RD
SPRINGFIELD PA 19064-1335
215-431-2610
KURTZ, MD, JAMES W P
564 CONESTOGA RD
BERWYN PA 19312-1363
LAFFEY, MD, PATRICIA A DR
429 OLD EAGLE SCHOOL RD
WAYNE PA 19087
LANGRALL, MD, HARRISON M IM
1857 BLACK ROCK LN
PAOLI PA 19301-1055
215-640-1884
LANSING, MD, DOROTHY I GYN
20 OLD PAOLI PIKE BOX 537
PAOLI PA 19301
LANZA, MD, RALPH A IM
PO BOX A
PAOLI PA 19301-0189
215-644-9456
LAPORTE, MD, STEVEN M CD
PAOLI MEMORIAL MEDICAL STE 20
PAOLI PA 19301
215-647-4260
LATOFF, MD, THOMAS J GP
533 E LINCOLN HWY
COATESVILLE PA 19320-3433
215-384-2484
LEE, MD, DANIEL IM
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COATESVILLE PA 19320-9801
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799 GAY ST
PHOENIXVILLE PA 19460-4456
215-933-2440
LEVIN, MD, GARY J * OPH
GREENVIEW PAVILION
THORNDALE PA 19372-1130
215-269-9100
LEWIS, MD, EARL T PA
233 CHATHAM WAY
WEST CHESTER PA 19380-6813
215-971-5510
LEWIS, MD, L CLIFFORD GP
421 MONUMENT AVE
MALVERN PA 19355-2215
215-644-4744
LIBERACE, MD, ETTORE V PTH
1126 TALLEYRAND RD
WEST CHESTER PA 19382-7462
LIMBERGER, MD, WILLIAM A IM
415 S BIRMINGHAM RD
WEST CHESTER PA 19382-2107
215-696-6027
LINDNER, MD, MARIE A NTR
831 HOLLOW RD
RADNOR PA 19087
215-662-7310
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799 GAY ST
PHOENIXVILLE PA 19460-4456
215-933-2440

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606 E MARSHALL ST
WEST CHESTER PA 19380-4440
215-696-1230
LONG, MD, DAVID F N
414 PAOLI PIKE
MALVERN PA 19355-3311
215-251-5450
LOOMIS, MD, MARIO G PS
460 CREAMERY WAY STE 110
EXTON PA 19341
215-524-8244
LOTZ, MD, ANDREW J GP
PO BOX 241
PAOLI PA 19301-0241
LOVRINIC, MD, WILLIAM S * OTO
9 N FIVE POINTS RD
WEST CHESTER PA 19380-4739
215-696-8800
LOWE, MD, CHERYL F PD
36 GLENNANN DR
LANDENBERG PA 19350-9631
LUCINE JR, MD, ALBERT A * OBG
795 E MARSHALL ST STE 304
WEST CHESTER PA 19380-4400
215-644-3775
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213 REECEVILLE RD STE 17
COATESVILLE PA 19320-1530
215-383-9400
LYONS, MD, CHRISTOPHER J * ORS
282 GLENRIDGE RD
GLENMORE PA 19343
215-524-8670
MACKENZIE, MD, NORMAN D GP
441 E LANCASTER AVE
DOWNINGTOWN PA 19335-2722
MAGEE, MD, JOAN M PD
500 HADFIELD RD
DOWNINGTOWN PA 19335-1136
215-269-9966
MAGGITTI, MD, MICHAEL J * ORS
479 THOMAS JONES WAY STE D
EXTON PA 19341-2552
215-524-8670
MAGNESS, MD, KATHLEEN E CD
151 LARCHWOOD CT
COLLEGEVILLE PA 19426-2903
215-933-8484
MAGUIRE, DO, F WILLIAM * IM
SOUTHERN CHESTER CTY MED BLDG
WEST GROVE PA 19390
215-869-3620
MAHER, MD, JOHN P GPM
326 N WALNUT ST
WEST CHESTER PA 19380-2624
215-344-6230
MARCUS, MD, DONALD J N
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COATESVILLE PA 19320
215-384-7711
MARINO, MD, MARK OBG
50 LAKEVIEW CT
DOWNINGTOWN PA 19335
215-269-8400
MARINO, DO, THOMAS N FP
1438 POTTSTOWN PIKE
WEST CHESTER PA 19380
215-431-9606
MARK, MD, WILLIAM S IM
PO BOX A
PAOLI PA 19301-0189
215-644-9456
MARSH, MD, CAROL L PD
101 COPE RD
KENNETT SQUARE PA 19348-2438
MAYER, MD, ROBERT A AN
50 HORSESHOE DR
THORNDALE PA 19372-1126
MCCHESNEY JR, MD, CHARLES T * HS
3500 LINCOLN HWY
THORNDALE PA 19372-1017
215-384-2420
MCGEEHAN, MD, JOHN T R
50 BLUE STONE DR
CHADDS FORD PA 19317-9311
MCKINSTRY, MD, ROBERT B FP
548 SCHOOL HOUSE RD
KENNETT SQUARE PA 19348
MCLAUGHLIN, MD, RAYMOND S * FP
1 W MEADOW WOODS LN
WEST GROVE PA 19390
215-444-4080
MELTZER, MD, ARTHUR H CD
578 RICHARDS RD
WAYNE PA 19087-1006
215-647-4260
MERSON, MD, ERICH R GP
134 W CHESTNUT ST
WEST CHESTER PA 19380
215-696-3606
MEYERS, MD, FREDERIC A * GE
213 REECEVILLE RD STE 38
COATESVILLE PA 19320
215-384-6076
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PHOENIXVILLE PA 19460
215-933-8454
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DEVON PA 19333

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24 RABBIT RUN
MALVERN PA 19355-3436

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2865 RINGNECK RD
AUDUBON PA 19403-1812
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904 MOUNTAINVIEW DR
WAYNE PA 19087-5542

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DEVON PA 19333
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401 W PLEASANT GROVE RD
WEST CHESTER PA 19382-7117
215-793-1687

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PHOENIXVILLE PA 19460-2553

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102 PUTNEY LN
MALVERN PA 19355-3206
215-696-4828

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WEST CHESTER PA 19380-4443
215-696-3431

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215-696-5855

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350 WALNUT AVE
WAYNE PA 19087-3624
215-688-2955

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258 FAGAN'S LN
WEST GROVE PA 19390-9245

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WEST CHESTER PA 19380-4341

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1256 LAKEMONT RD
VILLANOVA PA 19085-2104

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679 EWING RD
WEST GROVE PA 19390-9161
215-869-1288

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215-383-7075

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105 STIRRUP LN
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215-932-9118

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4 MCAVOY LN
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145 EATON DR
WAYNE PA 19087-3859

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17 GRUBB RD
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PHOENIXVILLE PA 19460-4444
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215-971-5502

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215-933-8484

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MERCY CATHOLIC MC-RAD THER
PHILADELPHIA PA 19143
215-748-9355

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318 CLEARFIELD DR
LINCOLN UNIV PA 19352-9006
215-526-3400

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WEST CHESTER PA 19380-4412
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PHOENIXVILLE PA 19460-4499
201-935-7772

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176 E CONESTOGA RD
DEVON PA 19333-1211
215-688-0822

ROSS, MD, PATRICIA E PD
358 FORREST MANOR RD
LINCOLN UNIV PA 19352-9610
215-869-3585

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WEST CHESTER PA 19380-5860

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PHOENIXVILLE PA 19460-3844
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CHESTER SPRINGS PA 19425-1000
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PAOLI PA 19301-1610
215-644-5000

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WEST CHESTER PA 19380-4412
215-431-5150

RUSSELL JR, MD, BERTRAM R R
520 ROSE LN
HAVERFORD PA 19041-1623

SACKS, MD, EDMOND J PDC
8 TIVERTON CIR
RADNOR PA 19087-2815
215-840-9966

SALAM, MD, MAHI PD
106 SCHUBERT DR
DOWNINGTOWN PA 19335-3382
215-873-8662

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PHILADELPHIA PA 19128-2412

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PAOLI MEMORIAL MEDICAL
PAOLI PA 19301

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15 GREEN ST
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319 N WOODMONT DR
DOWNINGTOWN PA 19335-3253
215-687-5060

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80 W WELSH POOL RD STE 101
EXTON PA 19341-1233
215-363-2409

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814 DENTON HOLLOW RD
WEST CHESTER PA 19382-7023
215-793-1979

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560 PUGH RD
STRAFFORD PA 19087-1907

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1763 HAMILTON DR
VALLEY FORGE PA 19481
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PO BOX A
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4335 W LINCOLN HWY STE 18
DOWNINGTOWN PA 19335-2226

SCOTT, MD, J CLIFFORD P
297 S COUNTY LANE RD
WAYNE PA 19087

SERKES, MD, CONSTANTINE A PD
39 MAY APPLE DR
DOWNINGTOWN PA 19335
215-524-5437

SHIREY, MD, ELAINE D AN
510 WILLIAMS RD
WYNNEWOOD PA 19096-2004
215-667-5413

SIEGEL, MD, MARY C P
BREEDER MILL
SPRING CITY PA 19475-9801
215-469-9079

SIEPSER, MD, STEVEN B * OPH
91 CHESTNUT RD
PAOLI PA 19301-1502
215-296-3333

SILVERBERG, MD, ALAN * OBG
799 GAY ST
PHOENIXVILLE PA 19460-4456
215-933-2442

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DEVON PA 19333

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795 E MARSHALL ST STE 303
WEST CHESTER PA 19380-4400
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17 WOODLAND CIR
DOWNINGTOWN PA 19335-3346

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614 MALLARD TER
WAYNE PA 19087-2326
215-383-8518

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KENNETT MEDICAL CENTER
KENNETT SQUARE PA 19348-2435
215-444-5678

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710 E LANCASTER AVE
EXTON PA 19341
215-524-3703

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750 S MAIN ST STE 203
PHOENIXVILLE PA 19460-4444
215-933-1133

SPENCER, MD, DONALD LYNN AN
PO BOX 401
KENNETT SQUARE PA 19348-0401

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506 E MARSHALL ST
WEST CHESTER PA 19380-4440
215-696-1230

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213 REECEVILLE RD STE 34
CALN TOWNSHIP PA 19320-1538
215-383-5810

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345 E CHESTNUT ST
COATESVILLE PA 19320
215-384-0250

STRETTON, MD, JEAN B IM
105 E EVANS ST
WEST CHESTER PA 19380-2600
215-383-1545

TADDONIO, MD, WILLIAM S FP
327 CATCH PENNY LN
MEDIA PA 19063-5420
215-444-5678

TEMPLE, MD, ANTHONY R PD
MCNEIL CONSUMER PRODUCT CO
FT WASHINGTON PA 19034
215-233-7763

THAKARAR, MD, PUSHPA US
1230 VICTORIA LN
WEST CHESTER PA 19380-4047

THEURKAUF JR, MD, EDWARD A IM
933 HAVERFORD RD
BRYN MAWR PA 19010-3819
215-525-0200

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85 CAROLYN DR
CHESTER SPRINGS PA 19425-2225
215-808-5227

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BRANDYWINE PROFESSIONAL BLDG
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215-384-9500

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PAOLI PA 19301
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WEST CHESTER PA 19380-4443
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140 NUTT RD
PHOENIXVILLE PA 19460-3906

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215-363-2409

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17 HITCHCOCK LN
GLEN MILLS PA 19342-1114
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215-383-0888

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PAOLI MEMORIAL MEDICAL BLDG
PAOLI PA 19301

WAGENFUHR, MD, TIMM DR
GLEN RD
LANDENBERG PA 19350-9801

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PHOENIXVILLE PA 19460-4444
215-933-5852

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213 REECEVILLE RD STE 34
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215-383-5610

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WEST CHESTER PA 19380
215-692-8280

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621 BROOKE LN
GLEN MILLS PA 19342-8824
215-383-8108

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135 PUTNEY LN
MALVERN PA 19355-3210

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WEST CHESTER PA 19382-4878
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PHOENIXVILLE PA 19460-4444
215-935-1330

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401 ADAMS AVE
SCRANTON PA 18510
717-346-7338
YEAGER, MD, HENRY C * NEP
746 JEFFERSON AVE
SCRANTON PA 18510-1624
YEVITZ, MD, WILLIAM J GP
1514 MADISON AVE
SCRANTON PA 18509-2442
ZAJAC, MD, ANDREJ J * RO
MERCY HOSPITAL
SCRANTON PA 18510-1624
717-348-7200
ZALE, MD, ANTHONY G ORS
1538 WYOMING AVE
SCRANTON PA 18509-2354
717-346-6111
ZAYDON, MD, ANNE C IM
312 W DRINKER ST
DUNMORE PA 18512
717-344-4449
ZEGLEN, MD, KURT T DR
915 POPLAR ST
DUNMORE PA 18510-1188
717-951-1606
ZENKER, MD, JOANNE S D
321 SPRUCE ST RM 439
SCRANTON PA 18503-1444
717-961-5522
ZUKOSKI, MD, THOMAS E PD
502 JEFFERSON AVE
SCRANTON PA 18510-1046
717-346-1464

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LANCASTER PA 17603-3239
717-397-1781
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618 N DUKE ST
LANCASTER PA 17602-2230
717-392-3596
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620 N DUKE ST
LANCASTER PA 17603-1604
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AHN, MD, CHANG W PM
530 N LAWN DR
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WILLOW STREET PA 17584-9529
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241 MAIN ST
LANDISVILLE PA 17538
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ALEXANDER, MD, ALAN R DR
209 BUCKFIELD DR
LITITZ PA 17543-9058
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ALLEN, MD, LISA S RHU
1065 OLDE HICKORY RD
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ALTADONNA, MD, VICTOR U
3166 GRANDE OAK PL
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990 E ORANGE ST
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BAIRD, MD, EDWARD F AN
1515 COUNTRY CLUB DR
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1351 BEACONFIELD LN
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21 CAMBRIDGE VLG
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EPHRATA PA 17522
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70 PEACH LN
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213 TOMAHAWK DR E
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23 ASHTON DR
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717-299-5511
DUPREY, MD, JAMES G FP
1261 HUNSICKER RD
LANCASTER PA 17601-5307
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EBERSOLE, MD, JOHN H TR
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LANCASTER PA 17601-5312
ECKENRODE, MD, JOSEPH L GP
1965 DREXEL AVE
LANCASTER PA 17602-3363
EISENHOWER, MD, EDWARD A * PTH
613 HEATHER LN
LANCASTER PA 17603-2332
EL-BORNO, MD, BASSAM M A CHP
30 STRATFORD VLG
LANCASTER PA 17602
ELKIN, DO, RICHARD J GE
1576 LITITZ PIKE
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130 S PENN ST
MANHEIM PA 17545-1749
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LANCASTER PA 17602-4905
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6 W NEWPORT RD
LITITZ PA 17543
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46 COUNTRY LN
LANDISVILLE PA 17538-1047
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317 N DUKE ST
LANCASTER PA 17602-4915
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LANCASTER PA 17602-2226
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179 N READING RD
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MUNCY PA 17756
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WEST NORRISTOWN PA 19403
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21 CHESWOLD DR
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215-354-3761
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WAYNE PA 19087-3812
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13 ARMAND HAMMER BLVD
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215-896-3335
NEWMAN JR, MD, CLYDE F OBG
1580 MCDANIEL DR
WEST CHESTER PA 19380-6673
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WEST POINT PA 19486
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DEVON PA 19333
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OLIVIERI, MD, SUZANNE P PD
67 RAMSGATE CT
BLUE BELL PA 19422-2550
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LANSDALE PA 19446-1200
215-361-4591
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958 COUNTY LINE RD
BRYN MAWR PA 19010-2502
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GILBERTSVILLE PA 19525-9785
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215-265-5795
VAN VOORHEES, MD, ABBY S D
LANSDALE MEDICAL GROUP
LANSDALE PA 19446
215-855-9501
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1400 WAVERLY RD VILLA 19
GLADWYNE PA 19035-1254
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3 HIDDEN LN
ABINGTON PA 19001-4603
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1630 CHADWYCK PL
BLUE BELL PA 19422-2912
215-223-2810
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1000 W VALLEY FORGE CIR # 110
KING OF PRUSSIA PA 19406-1107

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200 POLO DR
NORTH WALES PA 19454
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W CONSHOHOCKEN PA 19428
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1511 GLEN DR
MAPLE GLEN PA 19002-3106
215-728-2084
VOSSENBERG, MD, FRANS J IM
491 ALLENDALE RD
KING OF PRUSSIA PA 19406-1426
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ARDMORE PA 19003-2418
215-649-8244
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ABINGTON PA 19001-3714
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4190 BULGRAVE CT
WINSTON-SALEM NC 27104-1277
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904 STURGIS LN
LOWER GWYNEDD PA 19002-2021
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201 RICES MILL RD
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1 RED ROWAN LN
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101 S BRYN MAWR AVE STE 300
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215-525-1000
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MEDRL BL3-4
WEST POINT PA 19486
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1928 OLD HUNTINGDON PIKE
HUNTINGDON VLY PA 19006-7710
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34 WYNDMOOR DR
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DU BOIS PA 15801-2364
814-371-2360
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53 TIMBER WOOD DR
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132 VICTORIA LN
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BLOCH, MD, ROBERT S GS
1901 HAY TER
EASTON PA 18042-4650
215-252-2556

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370 S WALNUT ST
BATH PA 18014
215-837-8710

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2358 GROVER AVE
EASTON PA 18042-2808
215-252-2229

BOREEN, MD, STUART M AN
RR 9
BETHLEHEM PA 18015-9805
215-955-6161

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1436 BLACK RIVER RD
BETHLEHEM PA 18015-9032

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BETHLEHEM PA 18015-1153
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529 S MAIN ST
NAZARETH PA 18064-2716
215-252-8037

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2522 9TH ST
BETHLEHEM PA 18017-4330
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3543 GLEN AVE
EASTON PA 18042-5812
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387 CARVER DR
BETHLEHEM PA 18017-4718
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2431 EASTON AVE
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1945 RENWICK ST
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175 W NORTH ST
NAZARETH PA 18064-1439
215-252-2742
BYRNE, MD, JAMES E OS
1080 BLAKESLEE BLVD DR
LEHIGHTON PA 18235
CAMPO, DO, TARCISIO S * AN
RR 4 APPLE TREE LN
BETHLEHEM PA 18015-9002
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CANLAS, MD, JOLLY B * GP
5201 WILLIAM PENN HWY
EASTON PA 18042-2302
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CAPOBIANCO, MD, FRANK M EM
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CARDONE, MD, RICHARD A GS
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215-250-4000
CARLIN, MD, HUGH M AN
397 TIMOTHY DR
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3568 HECKTOWN RD
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250 S 21ST ST
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GREENSPAN, MD, BRUCE M * OTO
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BETHLEHEM PA 18018-2756
215-868-6900
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GLENSIDE PA 19038
215-885-2350

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1939 W CHELTENHAM AVE
ELKINS PARK PA 19117-1046
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4543 PULASKI AVE
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PENN VALLEY PA 19072-1139
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PHILADELPHIA PA 19107-5001
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PHILADELPHIA PA 19130

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332 WOODLAKE DR
MARLTON NJ 08053
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191 PRESIDENTIAL BLVD APT 706
BALA CYNWYD PA 19004-1230

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1500 LOCUST ST APT 4302
PHILADELPHIA PA 19102-4326
215-662-4000

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PHILADELPHIA PA 19131-2905

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8040 ROOSEVELT BLVD APT 217
PHILADELPHIA PA 19152-2902
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PHILADELPHIA PA 19115-3932
215-677-1100

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256 S 8TH ST APT 2
PHILADELPHIA PA 19107

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1722 BETHLEHEM PIKE
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PHILADELPHIA PA 19128-4809

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11663 BRANDON RD
PHILADELPHIA PA 19154-2532
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5458 RIDGE AVE
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275 BRYN MAWR AVE APT K59
BRYN MAWR PA 19010

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JENKINTOWN PA 19046

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PHILADELPHIA PA 19102-1012

BOLINGER, BEVERLY L ST
1600 HAGYS FORD RD APT 9Z
PENN VALLEY PA 19072-1049

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PHILADELPHIA PA 19107

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13 FLORA DR
PECKVILLE PA 18452-1004

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24 WOODLANE RD
LAURENIEVILLE NJ 08648

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PHILADELPHIA PA 19148-2911
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WALLINGFORD PA 19086-6658
215-221-2000

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ARDMORE PA 19003-2502

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BALA CYNWYD PA 19004-1589
215-664-9700

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1734 S AVONDALE ST
PHILADELPHIA PA 19142
BRADLEY, MD, JAMES P GS
239 S QUINCE ST
PHILADELPHIA PA 19107-6743
215-829-3000
BRADLEY JR, MD, ROBERT H *U
7913 CREFELD ST
PHILADELPHIA PA 19118-3938
BRADY, MD, JOSEPH J GS
8580 GLEN CAMPBELL RD
PHILADELPHIA PA 19128
BRADY, MD, LUTHER W TR
230 N BROAD ST
PHILADELPHIA PA 19102-1121
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822 PINE ST STE 3A
PHILADELPHIA PA 19107-6124
215-925-8010
BRAITMAN, MD, ROBERT A IM
539 PRESCOTT RD
MERION STATION PA 19066-1034
BRALOW, MD, S PHILIP GE
PEPPER PAVILION STE 100
PHILADELPHIA PA 19146
215-893-2532
BRANCATO, MD, JOHN C PD
1823 SPRUCE ST APT 5
PHILADELPHIA PA 19103-6324
215-437-5337
BRANDMAN, MD, ITA S IM
1208 CHILDS AVE
DREXEL HILL PA 19026-4102
215-423-1674
BRANICK, JOANNA R ST
422 S 44TH ST
PHILADELPHIA PA 19104-3927
BRAUN, MD, SARAH J CHP
HAHNEMANN UNIV HOSP MS 950
PHILADELPHIA PA 19102-1178
BRAUN, STEPHANIE M ST
226 W RITTENHOUSE SQ APT 513
PHILADELPHIA PA 19103
BRAUNSTEIN, LARRY ST
1426 MCKINLEY ST
PHILADELPHIA PA 19149-2705
BRAUTIGAM, ROBERT T ST
10 GEORGIAN CIR
NEWARK DE 19711-2551
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1317 WOLF ST
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215-389-0700
BRAY, MD, SUSAN H NEP
86 BETHLEHEM PIKE
PHILADELPHIA PA 19118-2821
215-247-3930
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8302 OLD YORK RD
ELKINS PARK PA 19117-1522
215-635-6885
BRECKENRIDGE, AMY C ST
3026 W QUEEN LN
PHILADELPHIA PA 19129-1035
BREECKER, MD, STEVEN W CD
3 SALISBURY LN
MALVERN PA 19355-2835
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BREINING, DWAYNE A ST
634 WHARTON ST 1ST FLR
PHILADELPHIA PA 19147-4822
BRENMAN, MD, ARNOLD K OT
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147 E BELLS MILL RD
PHILADELPHIA PA 19118-2616
215-829-7290
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1211 E BUTLER PIKE
AMBLER PA 19002-6032
BRENNAN, MD, JOSEPH E US
8203 CEDAR RD
PHILADELPHIA PA 19117-2113
BRENNER, MD, BARRY S FP
2175 KNORR ST
PHILADELPHIA PA 19149-2307
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BRENNER, DO, RICHARD P FP
2175 KNORR ST
PHILADELPHIA PA 19149-2307
215-624-2491
BRENT, GEOFFREY J ST
1960 DEERFIELD DR
LANSDALE PA 19446-5007
BREST, MD, ALBERT N CD
JEFFERSON MED COLL
PHILADELPHIA PA 19107
BREUNINGER, DO, HOLLY G NPM
2732 67TH ST
DES MOINES IA 50322-4913
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BRIAN, CHRISTOPHER M ST
834 CHESTNUT ST APT 504
PHILADELPHIA PA 19107-5136

BRIAN, JAMES M ST
1714 GREEN ST APT D
PHILADELPHIA PA 19130-3912
BRIGHTON, MD, CARL T ORS
14 FLINTSHIRE RD
MALVERN PA 19355-1108
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215-216 BARCLAY BLDG
BALA CYNWYD PA 19004
215-667-4815
BRILL, KRISTIN L ST
142 N JUNIPER ST
PHILADELPHIA PA 19107
BRINDISI, MD, GAETANO CD
917 COOPERTOWN RD
BRYN MAWR PA 19010-3721
BRISTOWE, KEVIN D ST
DONNA ANN APTS
PROSPECT PARK PA 19076
BRITTON, ERIC L ST
2201 PENNSYLVANIA AVE APT 415
PHILADELPHIA PA 19130
BRIZUELA, MD, HERNAN R OBG
5024 N 5TH ST
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192 ROLLING RD
BALA CYNWYD PA 19004-2615
215-955-6526
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87 SANDHURST DR
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BRODY, MD, MARION S *IM
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215-221-2000
BRODY, MD, MORRIS W PYA
2 W LEVERING MILL RD
BALA CYNWYD PA 19004-2605
215-664-7238
BROENNLE, MD, A MICHAEL AN
34TH ST AND CIVIC CTR BLVD
PHILADELPHIA PA 19104-4399
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1020 CEDAR GROVE RD
WYNNEWOOD PA 19096
BROGAN, MD, LOUIS E PD
6419 DREXEL RD
PHILADELPHIA PA 19151-2402
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NARBERTH PA 19072-1205
BROSS, RONALD J ST
GENERAL DELIVERY
DELANO PA 18220-9999
BROTHERS, BONNIE L ST
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PHILADELPHIA PA 19103-6802
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NE MEDICAL CTR STE 15
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PHILADELPHIA PA 19128-1926
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4422 PINE ST APT 1R
PHILADELPHIA PA 19104-3960
BROWN, MD, MELANIE C PM
7525 DEVON ST APT B101
PHILADELPHIA PA 19119-1010
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912 E WILLOW GROVE AVE
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301 CURTIN ST
OSCEOLA MILLS PA 16666-1201
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4025 WALNUT ST APT 2-R
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MCDONALD JR, DO, JAMES F CD
5401 OLD YORK RD
PHILADELPHIA PA 19141-3030
215-324-0551
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PHILADELPHIA PA 19107-5536
MCFARLAND, MD, MALCOLM D IM
95 WILLOW WAY MEADOWOOD
LANSDALE PA 19446
MCGEADY, MD, STEPHEN J * PDA
1025 WALNUT ST
PHILADELPHIA PA 19107-5001
215-928-8912
MCGEEHAN, MD, ANN M ST
106 COOPER ST
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MCGETTIGAN, MD, MARIE C PD
221 VINE ST APT 36
PHILADELPHIA PA 19106-1231
215-590-1653
MCGILL, MD, HERMAN I IM
923 MACDADE BLVD
COLLINGDALE PA 19023-3719
215-522-1222
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PHILADELPHIA PA 19107
MCGLAMERY, MD, MURIEL E * N
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MCGRATH, MD, THOMAS J ST
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PHILADELPHIA PA 19107-5901
MCGRAW, MD, THOMAS E OM
207 65TH AVE
PHILADELPHIA PA 19126-3905
MCGREGOR, MD, DEBORAH * GPM
208 E MOUNT AIRY AVE
PHILADELPHIA PA 19119-1717
215-924-9810
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45 MAYFLOWER DR
SICKLERVILLE NJ 08081-4120
MCINROY, BRIAN D ST
5535 RIDGE AVE
PHILADELPHIA PA 19128-2727
MCINTYRE, PATRICK E ST
325 N 15TH ST APT 1013
PHILADELPHIA PA 19102
MCKEE, MD, RODERICK S GS
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PHILADELPHIA PA 19114
215-632-3630
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242 STAMPERS ST
PHILADELPHIA PA 19147
MCKENNA, MD, SCOT R ST
1329 ELECTRIC ST
SCRANTON PA 18509-2014
MCKENZIE, MD, HARRY J ST
111 RODNEY DR
JOHNSTOWN PA 15904
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PHILADELPHIA PA 19129
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3112 GARNET MINE RD
BOOTHWYN PA 19061-1718
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NORRISTOWN PA 19401
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DEVON PA 19333-1429
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WYNNEWOOD PA 19096-1649
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PHILADELPHIA PA 19151-2012
MCNEIL-JACOBI, MD, ATHOLE G AN
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215-842-6795
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MCPEAK, MD, VINCENT J OBG
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MEADOWBROOK PA 19046-8099
215-938-2014
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215-925-2229
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6706 MALVERN AVE
PHILADELPHIA PA 19151-3020
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246 W UPSAL ST APT A203
PHILADELPHIA PA 19119
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PHILADELPHIA PA 19146-1703
215-471-2000
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77 MIDDLE RD APT 163
BRYN MAWR PA 19010-1756
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1650 HUNTINGDON PIKE STE 256
MEADOWBROOK PA 19046-8094
MEHROK, HARPAUL S ST
325 N 15TH ST APT 909A
PHILADELPHIA PA 19102-1030
MEISENHEIMER, HEATHER M ST
3426 HENRY AVE 3RD FL
PHILADELPHIA PA 19129-1117
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PHILADELPHIA PA 19139-2718
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PHILADELPHIA PA 19103
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MOUNT LAUREL NJ 08054-3351
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DREXEL HILL PA 19026-5323
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1025 WALNUT ST 3RD FL
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PHILADELPHIA PA 19103-6726
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166 SUMMIT LN
BALA CYNWYD PA 19004-2931
215-664-4716
MILLER, MD, C JOSEPH GE
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JENKINTOWN PA 19046
215-576-8026
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106 BENTLEY DR
MOUNT LAUREL N J 08054-4501
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PLANTATION FL 33322-5533
MILLER, DAVID R ST
3354 WIEHLE ST
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1700 BEN FRANKLIN PKWY # 1508
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304 MURRAY DR APT C
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PHILADELPHIA PA 19147-1408

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BALA CYNWYD PA 19004-1207
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HOSP UNIV OF PA
PHILADELPHIA PA 19104-4220
215-662-2014
MILLER, MD, MARK A IM
4000 GYPSY LN APT 601
PHILADELPHIA PA 19144-5542
MILLER, MD, MORRIS P
405 N OCEAN BLVD APT 1824
POMPANO BEACH FL 33062-5152
MILLER, PAMELA M ST
2991 W SCHOOL HOUSE LN
PHILADELPHIA PA 19144-5357
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PHILADELPHIA PA 19144-1403
215-843-4224
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1801 LOMBARD ST
PHILADELPHIA PA 19146
215-893-7272
MILLS, STEVEN E ST
3332 TILDEN ST
PHILADELPHIA PA 19129-1412
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534A WANAMAKER RD
JENKINTOWN PA 19046
MILLWARD JR, CARL L ST
317 S 11TH ST
PHILADELPHIA PA 19107-6034
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2321 SANSOM ST
PHILADELPHIA PA 19103-4308
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PHILADELPHIA PA 19107-5127
215-627-2525
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PHILADELPHIA PA 19131
MINCZAK, BOHDAN M ST
112 BONCOUER RD
CHELTENHAM PA 19012
MINEHART, MD, JOHN R GS
149 W WALNUT LN
PHILADELPHIA PA 19144-2611
MINERVA, MD, FELICISIMA B * AN
60 TOWNSHIP LINE RD
ELKINS PARK PA 19117-2249
215-663-6303
MINGRONI, DO, JULIUS A US
1439 E PASSYUNIC AVE
PHILADELPHIA PA 19147-5610
215-334-5656
MINION, MD, STEVEN L AN
520 S 19TH ST STE 1B
PHILADELPHIA PA 19146
215-545-4173
MINISSALE, DO, JOSEPH J IM
3684 STANTON ST
PHILADELPHIA PA 19129
MINK, MD, KENNETH R * ST
8170 MILLFAIR RD
MCKEAN PA 16426-1014
MINTON, MD, RUSSELL F DR
600 E CATHEDRAL RD APT 301-G
PHILADELPHIA PA 19128-1933
MINTZ, PHILIP S ST
325 SOTH 11TH ST APT 2
PHILADELPHIA PA 19107
MINTZER, MD, DAVID M ON
818-24 PINE ST STE 2A
PHILADELPHIA PA 19107
215-922-7200
MIRCHANDANI, MD, HARESH G * PTH
321 S UNIVERSITY AVE
PHILADELPHIA PA 19104-4543
215-823-7470
MISHKIN, MD, MARK M R
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PHILADELPHIA PA 19107
215-955-5445
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NORTH WALES PA 19454
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211 ARDLEIGH RD
NARBERTH PA 19072
215-896-6241
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4000-1719 PRESIDENTIAL BLVD
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547 HEATH RD
MERION STATION PA 19066-1422
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PHILADELPHIA PA 19103-5837
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MEDICAL ARTS BUILDING
ELKINS PARK PA 19117-2253
215-663-8200
SKOLNICK, MD, BRUCE A IM
66 VAN BUREN RD APT A3
VOORHEES NJ 08043-2325
215-985-8904
SKORPINSKI, MD, EDWARD W PD
CHILDRENS HOSPITAL OF PHILA
PHILADELPHIA PA 19104
215-590-1000
SKROMAK, MD, STANLEY J IM
5108 TORRESDALE AVE
PHILADELPHIA PA 19124-2220
215-232-4414
SKVERSKY, MD, NORMAN J PUD
1935 GULF OF MEXICO DR
LONGBOAT KEY FL 34228-3340
SLAP, MD, JOSEPH W P
1801 WALNUT ST FL 1312
PHILADELPHIA PA 19102-2913
215-563-8618
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1719 CAMBRIDGE CIR
SOUTHAMPTON PA 18966-4407
215-942-6000
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101 WEST AVE STE 106
JENKINTOWN PA 19046
215-572-7200
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2228 S BROAD ST
PHILADELPHIA PA 19145
215-467-8955
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400 GLENDALE RD # B23
HAVERTOWN PA 19083-3117
215-563-1199
SLOANE, MD, PAUL P
3 GRAPEVINE RD
GLOUCESTER MA 01930-4217
SLOCHOWER, MD, DENNIS OPH
1263 CLUB HOUSE RD
GLADWYNE PA 19035-1003
215-288-5000
SMITH, MD, A MITCHELL CD
A EINSTEIN MED CTR DAROFF DIV
PHILADELPHIA PA 19147
SMITH, MD, ARTHUR E IM
419 S 19TH ST
PHILADELPHIA PA 19146-1415
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SMITH, MD, ARTHUR K FP
535 PINE ST
PHILADELPHIA PA 19106-4110
215-922-5180
SMITH, MD, BUSTER DEANGELO P
424 W CHELTEN AVE 3RD FL
PHILADELPHIA PA 19144-4404
215-842-4193
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1200 OLD YORK RD
ABINGTON PA 19001
215-576-2024
SMITH, MD, ELLEN L EM
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TAMPA FL 33611-1803
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55 N 3RD ST APT 46
PHILADELPHIA PA 19106-4508
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SOLI, MD, SOLEIMAN M OBG
12200 ACADEMY RD
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2101 CHESTNUT ST APT 818
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SOLIT, RICHARD L ST
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SONG, SUNG W ST
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106 HARTLINE DR
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PHILADELPHIA PA 19107
STARK, BRIAN J N ST
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ERIE PA 16505
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STATLER, JOHN D ST
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PHILADELPHIA PA 19107-6703
STAUB, MD, ALICE W IM
7301 GHELBOURNE ST
PHILADELPHIA PA 19111-3011
STEEL, MD, HOWARD H ORS
SHINERS HOSP
PHILADELPHIA PA 19152-1299
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256 LANKENAU MED BLDG EAST
PHILADELPHIA PA 19151
215-649-1970
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PHILADELPHIA PA 19130
STEIKER, MD, DANIEL D PD
1939 W CHELTENHAM AVE
PHILADELPHIA PA 19117-1046
STEIN, MD, ANTHONY ST
317 N BROAD ST APT 806
PHILADELPHIA PA 19107
STEIN, MD, DANIEL E OBG
834 CHESTNUT ST APT 831
PHILADELPHIA PA 19107-5140
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8000 FRANKFORD AVE
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PENN VALLEY PA 19072
215-662-9842
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HILL HOUSE APT 206
HUNTINGDON VLY PA 19006
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2066 N OCEAN BLVD
BOCA RATON FL 33431-7802
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3247 DARBY RD
HAVERFORD PA 19041-1041
215-569-9500
STEIN, MD, NATALIO AN
246 LOCUST ST
PHILADELPHIA PA 19106-3901
STEINBERG, DAVID M ST
950 WALNUT ST APT 213
PHILADELPHIA PA 19107-5564
STEINBERG, MD, MARVIN E ORS
HOSP U OF P SILVERSTEIN 2
PHILADELPHIA PA 19104-4391
215-662-3340
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744 S 2ND ST
PHILADELPHIA PA 19147-3427
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201 S 18TH ST APT 1420
PHILADELPHIA PA 19103
215-662-7642

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PHILADELPHIA PA 19124
215-950-1950
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33 BELLA RD
MEDFORD NJ 08055
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1500 LOCUST ST APT 2106
PHILADELPHIA PA 19102-4317
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1465 KINGSLEY DR
WARMINSTER PA 18974
STEPPACHER, MD, LESTER G GS
220 LOCUST ST APT 30-C
PHILADELPHIA PA 19106-3933
STERLING, ROBERT S ST
512 GENERAL PATTERSON DR
GLENSIDE PA 19038-3202
STERLING, SCOTT W ST
122 WALNUT DRIVE
PARKESBURG PA 19365
STERN, MD, JOHN J ID
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PHILADELPHIA PA 19107-6124
215-925-8010
STERN, MD, LILLIAN H DR
METHODIST HOSP
PHILADELPHIA PA 19148-3594
215-952-9151
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215-590-1882
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142 SUMAC ST
PHILADELPHIA PA 19128

WALDMAN, MD, SCOTT A IM
1100 WALNUT ST MOB 813
PHILADELPHIA PA 19107-5502
215-955-5818

WALDMAN, MD, TERRY L IM
1128 SANDRINGHAM RD
BALA CYNWYD PA 19004-2023
215-664-1091

WALDNER, JOSEPH F ST
106 LINDA LN
CINNAMINSON NJ 08077-4274

WALINSKY, MD, PAUL CD
1025 WALNUT ST
PHILADELPHIA PA 19107-5001
215-955-8860

WALKER, ANNE M ST
506 EATON RD
DREXEL HILL PA 19026

WALKER, MD, BARRY R IM
714 PENNSTONE RD
BRYN MAWR PA 19010-2913

WALKER, GREGORY E ST
507 POPLAR ST
LANSDALE PA 19446-1918

WALKER, MD, HERBERT I P
THE BENSON EAST RM B202
JENKINTOWN PA 19046
215-884-2323

WALKER, MD, KIMBERLY C P
459A W ELLET ST
PHILADELPHIA PA 19119
215-842-4406

WALKER, MD, M LORENZO FP
5740 W GIRARD AVE
PHILADELPHIA PA 19131-4812
215-877-1110

WALKER, MD, MARGARET E IM
1201 LIMBERLOST LN
GLADWYNE PA 19035-1410
215-359-1355

WALKER, MATTHEW T ST
1000 WALNUT ST APT 1811
PHILADELPHIA PA 19107-5537

WALKER JR, MD, LEROY L CD
4107 TIMBER LN APT 402
PHILADELPHIA PA 19144-5425
215-848-2336

WALLACE, MD, IRA B OPH
231 TOWER LN
NARBERTH PA 19072-1127
215-882-8100

WALLACE, MD, RICHARD P IM
302 S 19TH ST
PHILADELPHIA PA 19103-6615
215-735-6627

WALLIN, MD, BRUCE A * RHU
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PHILADELPHIA PA 19130-4009
215-751-6366

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215-247-3552

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215-335-6216

WANG, JOHN Y ST
3600 CHESTNUT ST APT 1225
PHILADELPHIA PA 19104-6119

WANG, MD, THOMAS N GS
5500 WISSAHICKON AVE # 710A
PHILADELPHIA PA 19144-5643

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215-955-6315

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2401 PENNSYLVANIA AVE # 10B24
PHILADELPHIA PA 19130-3061
215-236-2354

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ONE CHRISTIAN ST #34
PHILADELPHIA PA 19147

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301 S 19TH ST APT 15D BOX 86
PHILADELPHIA PA 19103

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PHILADELPHIA PA 19107
215-829-3541

WARK, MD, JAMES E CHN
112 SCHOOL HOUSE LN
ARDMORE PA 19003-3310
215-642-6650

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3401 N BROAD ST
PHILADELPHIA PA 19140-5103
215-221-3347

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368 BYRON RD
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2408 N 32ND ST
PHILADELPHIA PA 19132-3306
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215-246-5100

WASSERMAN, CHANA S ST
4105 SPRUCE ST APT D3
PHILADELPHIA PA 19104-4049

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223 HEADHOUSE CT
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215-448-8500

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4609 BAYARD ST APT 1
PITTSBURGH PA 15213-2727

WEBER, ERIC A ST
336 QUEEN ST APT 31
PHILADELPHIA PA 19147-3216

WEBER, MD, JOHN I FP
7254 HORROCKS ST
PHILADELPHIA PA 19149-1219
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55 E GATE DR
PHOENIXVILLE PA 19460-1701

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WEIBEL, CHRISTOPHER J ST
3610 HAWOOD ST
PHILADELPHIA PA 19129-1518

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6732 EMLEN ST
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215-843-8000

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4600 UNIVERSITY DR APT 1217
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6918 GRANT AVE
PENNSAUKEN NJ 08109-2750

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WYNNEWOOD PA 19096-3811
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PHILADELPHIA PA 19104-4220
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215-333-0900

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11 MARTINS RUN APT B206
MEDIA PA 19063-1059
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1325 W TABOR RD
PHILADELPHIA PA 19141-3020
215-548-2252
WEINER, MD, LEON J IM
8473A BUSTLETON AVE
PHILADELPHIA PA 19115-2611
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FRANKFORD HOSP
PHILADELPHIA PA 19114
215-934-4749
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1212 CHERMAR LN
PENN VALLEY PA 19072-1138
215-667-2579
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266 S 21ST ST APT 3-F
PHILADELPHIA PA 19103
215-731-0711
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412C BAINBRIDGE ST
PHILADELPHIA PA 19147
WEINSTEIN, LISA F ST
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PHILADELPHIA PA 19144-5444
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1521 LOCUST ST FL 10
PHILADELPHIA PA 19102-3727
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331 GROFF MILL RD #37-C
HARLEYSVILLE PA 19438-2142
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PHILADELPHIA PA 19144-4449
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215-487-0966
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PHILADELPHIA PA 19107
WEISS, MD, ALBERT A ORS
230 N BROAD ST
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WEISS, MD, BURTON P
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PHILADELPHIA PA 19107-1511
215-569-8736
WEISS, MD, CHARLES US
412 W MOUNT AIRY AVE
PHILADELPHIA PA 19119-2946
WEISS, MD, DAVID L * DR
313 CHERRY LN
WYNNEWOOD PA 19096-1710
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405A SHAWMONT AVE
PHILADELPHIA PA 19128
WEISS, MD, EDWARD D CRS
2401 PENNA AVE APT 19B24
PHILADELPHIA PA 19130
WEISS, MD, ERIC G GS
405 SHAWMONT AVE APT A
PHILADELPHIA PA 19128-4005
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WEISS, MD, JORDAN S GE
EPISCOPAL HOSP
PHILADELPHIA PA 19125
WEISS, MD, LAURENCE S P
2401 PENNSYLVANIA AVE APT 18A
PHILADELPHIA PA 19130-3057
WEISS, MD, ROBERT IM
191 PRESIDENTIAL BLVD
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WEISS, MD, SIDNEY OPH
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DARBY PA 19023-1333
215-534-6327
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WEISS, MD, WILLIAM OM
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PHILADELPHIA PA 19143
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PHILADELPHIA PA 19111-2437
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PHILADELPHIA PA 19102-1713
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35 ELM ST
ELDRED PA 16731

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JEFFERSON HOSP
PHILADELPHIA PA 19107-4824
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2400 CHESTNUT ST APT 411
PHILADELPHIA PA 19103-4314
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WELSH, SCOTT R ST
3584 INDIAN QUEEN LN
PHILADELPHIA PA 19129-1540
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1015 WALNUT ST RM 401
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PHILADELPHIA PA 19140-5103
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219 GRAYLING AVE APT 4
NARBERTH PA 19072-1903
WENGER, MD, SIDNEY U P
PRESIDENTIAL APTS D129
PHILADELPHIA PA 19131
215-878-5233
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1409 HILLSIDE DR
WYNNEWOOD PA 19096
215-448-8700
WERNING, MD, JOHN W GS
4040 PRESIDENTIAL BLVD # 2612
PHILADELPHIA PA 19131-1732
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5049 OXFORD AVE
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215-288-2343
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A EINSTEIN MED CTR
PHILADELPHIA PA 19141
215-456-7021
WESS, MD, MICHAEL M IM
262 S 21ST ST # 4
PHILADELPHIA PA 19103-4819
215-662-3924
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7816 CONWELL RD
LAVEROCK PA 19118-1205
WEST, STEVEN E ST
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PHILADELPHIA PA 19104-6092
WESTCOTT, MD, CARL J GS
554 N 16TH ST
PHILADELPHIA PA 19130
WETMORE, MD, RALPH F * OTO
CHILDRENS HOSP OF PHILA
PHILADELPHIA PA 19104
215-590-2458
WETTLAUFER, MD, MARILYN R OBG
TORRESDALE MED CTR SUITE 305
PHILADELPHIA PA 19114
215-281-3000
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41 CONSHOHOCKEN STATE RD
BALA CYNWYD PA 19004-2438
WEYN, MD, DAVID C DR
2005 TOWNLINE WAY
BLUE BELL PA 19422-3465
215-458-8200
WHIPPLE, MD, DOROTHY S D
1335 W TABOR RD APT 205
PHILADELPHIA PA 19141-3040
215-548-7575
WHITAKER, MD, LINTON A PS
10 PENN TOWER 3400 SPRUCE ST
PHILADELPHIA PA 19104
215-662-2048
WHITCOMB, MD, CLARENCE A OS
100 W WALNUT LN
PHILADELPHIA PA 19144-2612
WHITCOPF, PETER J ST
4314 DOBSON ST
PHILADELPHIA PA 19129
WHITE, MD, DANETTE IM
111 CHESTNUT ST
CHERRY HILL NJ 08002
215-471-2750
WHITE, MD, DAVID M GS
7602 CENTRAL AVE STE 201
PHILADELPHIA PA 19111-2402
WHITE, JOHN E ST
114 CONWAY AVE
NARBERTH PA 19072-2202
WHITE, KAREN L ST
412 LINDEN ST
JENKINTOWN PA 19046
WHITE, MD, KELLEY J PD
251 E BRINGHURST ST
PHILADELPHIA PA 19144-1719
215-844-1020
WHITEFORD, MD, MARK H GS
201 S 12TH ST APT 4A
PHILADELPHIA PA 19107-5503
WHITEHOUSE, JULIE A ST
919 CLINTON ST
PHILADELPHIA PA 19107-6109
WHITENACK, MD, STEPHEN H TS
8400 ST MARTINS LN
PHILADELPHIAPA 19118-3724
WHITMAN, JAMES F ST
1512 SPRUCE ST APT 16C
PHILADELPHIA PA 19102-4524
WHITMAN, MD, MARC S ID
440 WASHINGTON TER
AUDUBON NJ 08106

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8510 CASTOR AVE
PHILADELPHIA PA 19149-2106
215-745-7107
WHYTE, MD, JOHN PM
1200 W TABOR RD
PHILADELPHIA PA 19141
215-456-8485
WHYTE, JOHN J * ST
317 N BROAD ST APT 618
PHILADELPHIA PA 19107
WIDELITZ, MD, MARTIN M IM
243C SHAWMONT AVE
PHILADELPHIA PA 19128-4209
215-878-5600
WIDER, MD, SAUL PD
359 SPRING VALLEY RD
SPRINGFIELD PA 19064-2231
WIDRA, MD, ERIC A OBG
252 S QUINCE ST
PHILADELPHIA PA 19107-6747
WIEDER JR, MD, HENRY S ORS
UNITED MEDICAL PHILADELPHIA
PHILADELPHIA PA 19103-2703
215-972-3500
WIENER, MD, JACOB S * IM
2408 S 5TH ST
PHILADELPHIA PA 19148-3908
215-334-2418
WIGHT, MD, SUSAN C PD
3300 S PENINSULA DR
DAYTONA BEACH FL 32118-6351
WIKLER, MD, LOUIS A FP
1158 OLD YORK RD
ABINGTON PA 19001-3713
215-884-2900
WIKLER, MD, MATTHEW A ID
FOUR FALLS CORPORATE CTR
KING OF PRUSSIA PA 19406
215-751-6361
WIKOFF, MD, EDWARD K PM
MOSS REHAB HOSP
PHILADELPHIA PA 19141
215-456-9495
WILBRAHAM, STEVEN C ST
1812 CALLOWHILL ST APT 3F
PHILADELPHIA PA 19130-4110
WILBUR, MD, SABRINA L CD
220 LOCUST ST APT 29F
PHILADELPHIA PA 19106-3933
215-427-7000
WILF, MD, HAROLD OTO
375 TOWNSHIP LINE RD
ELKINS PARK PA 19117-2257
WILKENS, JILL C ST
508 CANDACE LN
VILLANOVA PA 19085
WILLIAMS, MD, F MARIAN OBG
4115 TIMBER LN
PHILADELPHIA PA 19144-5425
WILLIAMS, MD, JAMES R PTH
700 POLO RD
BRYN MAWR PA 19010-3826
215-334-2494
WILLIAMS, MD, JAY JAMES AN
1 WINEBERRY DR
HOCKESSIN DE 19707-2124
215-328-8181
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3200 N BROAD ST
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215-324-3800
WILLIAMS, MD, KAREN A PD
555 MEADOWBROOK DR
HUNTINGDON VALLEY P 19006-6848
215-288-2727
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500 ESHERICK RD
WAYNE PA 19087-4716
215-527-1185
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215-893-0132
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WILLNER, MD, IRA R IM
834 CHESTNUT ST APT 613
PHILADELPHIA PA 19107-5137
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1801 SPRING GARDEN ST APT 307
PHILADELPHIA PA 19130-3943
WILSON, MD, GEORGE M GS
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1438 COLWELL LN APT 304
CONSHOHOCKEN PA 19428
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325 N 15TH ST APT 1301
PHILADELPHIA PA 19102
WINER, LISA A ST
261 S 10TH ST APT 3
PHILADELPHIA PA 19107-5564
WINFREE, MD, LISTERVELT S OS
1 BAILY RD
YEADON PA 19050-2617
WINSON, MD, SAMUEL G OBG
255 S 17TH ST
PHILADELPHIA PA 19103-6230
215-735-4822
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7901 BUSTLETON AVE STE 200
PHILADELPHIA PA 19152-3302
215-332-4000
WINTERS, ELIZABETH A M * ST
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ANDALUSIA PA 19020-7727
WIRTS JR, MD, C WILMER GE
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WISGO, CHRISTOPHER J ST
206 S 13TH ST APT 1505
PHILADELPHIA PA 19107-5427
WISNIEWSKI, RALPH M ST
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PHILADELPHIA PA 19130
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WOHL, MD, MILTON A * ORS
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WOLF, ABIGAIL ST
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PHILADELPHIA PA 19119
WOLF, ERICA ST
407 LONGFIELD RD
ERDENHEIM PA 19118-1340
WOLF, MD, LEWIS R OPH
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PHILADELPHIA PA 19152-3321
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PHILADELPHIA PA 19103-4625
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WOLLMAN, MD, HARRY AN
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215-448-4401
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FOXCROFT SQUARE APT 726
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WOMACK, LAWRENCE H ST
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PHILADELPHIA PA 19144

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3885 PINE RD
HUNTINGDON VLY PA 19006-2418
215-947-5562
WONG, EDMOND Y ST
3120 W SCHOOLHOUSE LN APT MA4
PHILADELPHIA PA 19144
WOO, MD, Y JOSEPH ST
3938 PINE ST
PHILADELPHIA PA 19104
WOOD, MD, JAMES E IM
623 CASTLEFINN LN
BRYN MAWR PA 19010
215-248-2313
WOOD, LAURA M ST
1801 SPRING GARDEN ST
PHILADELPHIA PA 19130-3940
WOOD, MD, MOIRA D PTH
8268 CHURCH RD
PHILADELPHIA PA 19151-2503
215-842-8300
WOOD, RANDOLPH S ST
3443 TILDEN ST
PHILADELPHIA PA 19129-1434
WOODBURY, DEBORAH ST
649 S HENDERSON RD APT C310
KING OF PRUSSIA PA 19406-3583
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PHILADELPHIA PA 19118—261
215-248-8577
WOODS, KELLY W ST
3458 SUNNYSIDE AVE # 2
PHILADELPHIA PA 19129-1433
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BALA CYNWYD PA 19004
215-664-1977
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215-228-9090
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19 HEATH CT
ERIAL NJ 08081
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111 E LEVERING MILL RD
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215-387-1200
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215-829-3561
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3479 TILDEN ST
PHILADELPHIA PA 19129-1434
215-928-6005
WU, HSI-YANG ST
4521 SPRUCE ST APT 2
PHILADELPHIA PA 19139-4571
WU, KENNETH D ST
3447 AINSLIE ST
PHILADELPHIA PA 19129-1425
WU, LILLIAN ST
950 WALNUT ST APT 212
PHILADELPHIA PA 19107-5564
WU, PETER C ST
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PHILADELPHIA PA 19107-5149
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PHILADELPHIA PA 19140
WYSZYNSKI, DO, EUGENE J HEM
1843 S BROAD ST
PHILADELPHIA PA 19148
215-468-8008
XAVIER, MD, CHERIAN P IM
7505 VALLEY AVE
PHILADELPHIA PA 19128-3130
YAKIN, DAVID E ST
1801 JOHN F KENNEDY BLVD
PHILADELPHIA PA 19103-1724
YAN, ALBERT C ST
2220 SUMMER ST
PHILADELPHIA PA 19103-1015
YANG, LYNN W ST
950 WALNUT ST
PHILADELPHIA PA 19107-5596
YANG, MD, SHUIN-LIN GS
1025 WALNUT ST RM 604
PHILADELPHIA PA 19107-5001
215-955-5818
YANG, THOMAS S ST
1801 JFK BLVD APT 2210
PHILADELPHIA PA 19103

YANKELEVICH, MD, RAUL GP
1230 LOCUST ST
PHILADELPHIA PA 19107
YANNI, MD, ANTHONY J ST
R 608 LANGSTAFF PL
SCRANTON PA 18508
YANOFF, MD, MYRON OPH
216 N BROAD ST MS 209
PHILADELPHIA PA 19102-1101
YANOVSKI, MD, A VIVIAN IM
5501 GREENE ST
PHILADELPHIA PA 19144-2805
215-848-7600
YANOVSKI, MD, ALEXANDER G P
5501 GREENE ST
PHILADELPHIA PA 19144-2805
215-848-7601
YANOVSKI, MD, JACK A PD
5000 BATTERY LN APT 801
BETHESDA MD 20814-2846
215-886-1811
YANUS, BARBARA J ST
4740 PINE ST APT D3
PHILADELPHIA PA 19143-1853
YAROSH, CHERYLON A ST
313 E WILLOW ST APT 510
SYRACUSE NY 13203
YARRA, MD, NIRMALA P
1094 DIXON LN
RYDAL PA 19046-2431
609-396-8261
YARROW, MD, MORRIS W CD
17 LINDEN LN
ELKINS PARK PA 19117-1333
215-342-3111
YAVIL, DO, JULES S DR
351 BAIRD RD
MERION STATION PA 19066-1414
YAZDANFAR, MD, SHAHRIAR * CD
A EINSTEIN MED CTR
PHILADELPHIA PA 19141
215-456-7022
YAZDI, SHAHRAD ST
2028 GREEN ST APT 3R
PHILADELPHIA PA 19130
YEE, MD, MARIA R P
3712 TAYLOR AVE
DREXEL HILL PA 19026-3012
215-221-3351
YEN, DENIS A ST
1801 JFK BLVD # 810
PHILADELPHIA PA 19103
YI, HYO G ST
1801 JFK BLVD # 2903
PHILADELPHIA PA 19103
YIM, KENNETH B ST
325 N 15TH ST APT 701
PHILADELPHIA PA 19102
YIN, MD, ELAINE OBG
3202 WHITNEY CT
BENSALEM PA 19020
YIP, MARGIE D ST
3400 HENRY AVE APT 3R
PHILADELPHIA PA 19129
YODER, MD, STEPHEN E IM
732 PINE ST APT 4F
PHILADELPHIA PA 19106-4008
215-829-3521
YOO, PETER J ST
12981 AUGUST CIR
RIVERSIDE CA 92503-0917
YOON, MD, CHUNG H GP
5031 N 5TH ST
PHILADELPHIA PA 19120-3834
215-324-0230
YOON, MI-YUNG ST
319 S 10TH ST APT 134
PHILADELPHIA PA 19107
YOUN, PETER Y ST
3921 PINE ST APT 3F
PHILADELPHIA PA 19104-4101
YOUNG, MD, GERALDINE P PTH
681 MEETINGHOUSE RD APT 7
PHILADELPHIA PA 19117-1536
YOUNG, MD, IRVING PTH
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PHILADELPHIA PA 19117-1536
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YOUNG, MD, NANCY ANNE PTH
925 DALE RD
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215-887-3117
YOUNG, MD, TERRI L OPH
CHILDRENS HOSPITAL OF PHILA
PHILADELPHIA PA 19104
215-590-2791
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1 PENN BLVD
PHILADELPHIA PA 19144-1498
215-951-8926
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215-427-7000

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60 TOWNSHIP LINE RD
PHILADELPHIA PA 19117-2249
YUN, ELIZABETH S ST
325 N 15TH ST APT 1610
PHILADELPHIA PA 19102-1011
YUNIS, MD, JORGE J PTH
911 SUMMIT RD
PENN VALLEY PA 19072-1324
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1509 SWEET BRIAR RD
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ZALE, NANNETTE R ST
950 WALNUT ST APT 607
PHILADELPHIA PA 19107-5564
ZAMOSTIEN, MD, BERNARD B FP
1335 W TABOR RD APT 303
PHILADELPHIA PA 19141-3041
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2317 S BANCROFT ST
PHILADELPHIA PA 19145
ZANGWILL, MD, BRUCE C PTH
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PHILADELPHIA PA 19129-1516
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506A GLEN ECHO RD
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2375 WOODWARD ST APT 809
PHILADELPHIA PA 19115-5124
ZEITZER, MD, KENNETH L TR
950 WALNUT ST APT 403
PHILADELPHIA PA 19107-5564
ZEITZER, RANDI J ST
950 WALNUT ST APT 403
PHILADELPHIA PA 19107-5564
ZELAC, DANIEL E ST
8150 NEW SECOND ST
ELKINS PARK PA 19117-2719
ZELAHY JR, JOHN W ST
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PHILADELPHIA PA 19144-4543
ZELINSKY JR, MD, JOSEPH J ST
3026 W QUEEN LA APT B3B
PHILADELPHIA PA 19129
ZELLIS, DO, JOSEPH FP
1921 MORRIS ST
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1200 OLD YORK RD
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WYNNEWOOD PA 19096-2611

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ZGLEBZEWSKI, TIMOTHY M ST
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BROOKHAVEN PA 19015-1012
ZIGERMAN, DO, HERBERT L FP
151 MEADOWBROOK DR
HUNTINGDON VALLEY P 19006
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WASHINGTON PA 15301-2818
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3450 S OCEAN BLVD APT 217
PALM BEACH FL 33480-5936
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191 PRESIDENTIAL BLVD # 1021
BALA CYNWYD PA 19004
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1722 BETHLEHEM PIKE
FLOURTOWN PA 19031-1644
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ZUSMAN, EHUD I ST
2821 W QUEEN LN
PHILADELPHIA PA 19129
ZWEIZIG, MD, HELEN Z PD
538 WALNUT LN
PHILADELPHIA PA 19128-1741
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CHARLES COLE MEMORIAL HOSP
COUDERSPORT PA 16915
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EMPORIUM PA 15834-1416
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207 CARTEE ST
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MOSCH, MD, HERMAN C AN
5 ALLEGANY AVE
COUDERSPORT PA 16915-1308
NURBHAI, MD, MURTAZA E * OTO
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COUDERSPORT PA 16915
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55 S EAST ST
COUDERSPORT PA 16915-1406
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TROUTMAN, MD, HOLMES R GS
RTE 6 EAST
COUDERSPORT PA 16915
814-274-9300
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46 S MAIN ST
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POTTSVILLE PA 17901-3001
717-622-5751
ASLAM, MD, MOHAMMAD N
101 MILL CREEK AVE
POTTSVILLE PA 17901
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BANE, MD, DENIS M IM
1 NORWEGIAN PLZ
POTTSVILLE PA 17901-3056
717-622-0907
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RR 1 BOX 123
ANDREAS PA 18211-9784
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PO BOX 332
ORWIGSBURG PA 17961-0332
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W MAIN ST PO BOX 660
VALLEY VIEW PA 17983-9705
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316 MAUCH CHUNK ST
POTTSVILLE PA 17901-3614
BEMILLER, MD, CARL CD
205 E LAUREL BLVD
POTTSVILLE PA 17901-2534
717-622-1887
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150 AVENUE E
SCHUYLKILL HAVEN PA 17972-1412
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BIZUP, MD, THOMAS GP
PO BOX 148
NEW RINGGOLD PA 17960-0148
717-943-2424
BLOSCHICHAK, MD, ANDREW FP
320 GOFORTH DR
HAVRE DE GRACE DE 21078-4100
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520 BARING DR
ORWIGSBURG PA 17961-2204
BORAN, MD, ROBERT P * ORS
313 WASHINGTON ST
POTTSVILLE PA 17901-3640
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222 N 12TH ST
READING PA 19604-2964
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BOYSEN, MD, HOMER GP
238 W PINE ST
MAHANOY CITY PA 17948-2539

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700 SCHUYLKILL MANOR RD
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463 BARCLAY RD
ROSEMONT PA 19010-1253
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CROLEY, MD, JAMES T GP
523 S GARFIELD AVE
SCHUYLKILL HAVEN PA 17972-1107
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CUBLER, MD, EDWARD W AN
119 AVENUE B
SCHUYLKILL HAVEN PA 17972-1304
CURRY, MD, THOMAS A PD
316 MAUCH CHUNK ST
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419 W MARKET ST
POTTSVILLE PA 17901-2930
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1716 BREEZY ACRES RD
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801 BARING DR
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FEUDALE, MD, RICHARD F * GP
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717-875-0380
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205 E LAUREL BLVD
POTTSVILLE PA 17901-2534
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211 TIMBER RD
POTTSVILLE PA 17901-4036
717-622-9508
FRABLE, MD, DEAN G IM
413 W MARKET ST
POTTSVILLE PA 17901-2930
717-628-2040
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ANDERSON, MD, LEONARD S PHILADELPHIA
ANDERSON, PENNY R STUDENT
ANDERSON, MD, RICHARD E ALLEGHENY
ANDERSON, MD, RONALD B DELAWARE
ANDERSON, MD, THOMAS E FRANKLIN
ANDERSON, THOMAS M STUDENT
ANDERSON, MD, VICTOR S WESTMORELAND
ANDERSON, MD, WILLIAM C VENANGO
ANDERSON, MD, WILLIAM M DAUPHIN
ANDERSON JR, MD, LYLE F DAUPHIN
ANDERSON JR, MD, WILLIAM H ERIE
ANDREOZZI, MD, ROBERT J LEBANON
ANDRES, CHRISTOPHER D STUDENT
ANDRES, DO, DAVID M STUDENT
ANDREW-JAJA, MD, CAREY D ALLEGHENY
ANDREWS, MD, A THOMAS DAUPHIN
ANDREWS, MD, JOSEPH J LUZERNE
ANDREWS, MD, P JOSEPH DAUPHIN
ANDREWS, MD, PAUL J LUZERNE
ANDREWS, MD, PETER J LUZERNE
ANDREWS, SCOTT K STUDENT
ANDREWS, MD, WAVERLY S PHILADELPHIA
ANDREWS III, MD, WILLARD G MONTGOMERY
ANDREWS-MURRAY, MD, GAYLE YORK
ANDRIES, MD, RAYMOND C DELAWARE
ANDRIES, MD, RAYMOND M MONTGOMERY
ANDRILLI, JOHN A STUDENT
ANDRIOLA, MD, FRANK J DAUPHIN
ANDRIOLE, DO, JAMES M CLINTON
ANDRIOLE, MD, JOSEPH P LACKAWANNA
ANDROKITES, MD, ARTHUR T DAUPHIN
ANDROSKI, MD, ANNE A STUDENT
ANDROSKI, MD, JOHN J LACKAWANNA
ANEGAWA, NORIFUSA J STUDENT
ANEJA, MD, SURINDER K ALLEGHENY
ANGELES, MD, ANNE MARIE C PHILADELPHIA
ANGELUCO, MD, RICHARD J LEHIGH
ANGELO, MD, JOHN J YORK
ANGELO, DO, SHARON A PHILADELPHIA
ANGLE, MD, WILLIAM D LYCOMING
ANGLES, MD, CARMEN PHILADELPHIA
ANGOOD, MD, PETER B PHILADELPHIA
ANGSTADT, MD, JOANN FRANKLIN
ANGSTADT, MD, TERRY L FRANKLIN
ANGSTADT JR, MD, PAUL N MONTGOMERY
ANGULO, MD, ARMAND J FRANKLIN
ANGUS, MD, LESLIE R MONTOUR
ANHALT, MD, JOHN P MONTOUR
ANISH, ERIC J STUDENT
ANISTRANSKI, MD, JOSEPH A LUZERNE
ANKER, MD, PETER M DAUPHIN
ANNESLEY JR, MD, WILLIAM H DELAWARE
ANNEST, MD, STEPHEN J BRADFORD
ANNON JR, MD, WALTER T PHILADELPHIA
ANO, MD, ANTONIO C PHILADELPHIA
ANOLIK, MD, MITCHELL A PHILADELPHIA
ANOLIK, MD, STEVEN L BEAVER
ANON, MD, JACK B ERIE
ANSARI, MD, AMIR H ALLEGHENY
ANSELMI, MD, LANNING A LUZERNE
ANSLEY, MD, MARK W BUCKS
ANSON, MD, PETER M LEHIGH
ANTALIK, MD, PAUL E ALLEGHENY
ANTEMANN, MD, RICHARD W CAMBRIA
ANTENSON, MD, CHARLES M PHILADELPHIA
ANTHONY, MD, JOHN A MONTGOMERY
ANTI, MD, ALVISE G ALLEGHENY
ANTO, MD, DAVID P WESTMORELAND
ANTOGNOLI, MD, WILLIAM J LACKAWANNA
ANTONCIC, MD, RUDY ALLEGHENY
ANTONELLI, MD, ELENA C BUCKS
ANTONELLO JR, MD, ANTHONY DELAWARE
ANTONETTI, MD, THOMAS B LYCOMING
ANTONIADES, MD, JOHN PHILADELPHIA
ANTONOFF, MD, ROSS S PHILADELPHIA
ANTONUCCI, MD, DONNA L MONTGOMERY
ANTOON, DO, MICHAEL S ERIE
ANTOON JR, MD, SALEEM J WESTMORELAND
ANTOS, MD, JOHN M BRADFORD
ANTOS, MD, THOMAS J ALLEGHENY
ANTYPAS, MD, PHILIP G ALLEGHENY
ANWAR, IQBAL A STUDENT
ANZALONE, MD, ANGELO A LUZERNE
ANZALONE, MD, SALVATORE BERKS
APOLINARIO, MD, ARTURO A PHILADELPHIA
APOSTOLOU, MD, GEORGE C PHILADELPHIA
APPASAMY, MD, RAGUNATH ALLEGHENY

APPEL, MD, JOHN W	PHILADELPHIA
APPLE, MD, RICHARD J	ALLEGHENY
APPLEGATE, DO, DAVID J	BEAVER
APPLEGATE, MD, GERALD B	BUTLER
APPLEGATE, MD, RUSSEL C	DELAWARE
APPLESTEIN, MD, BRUCE	BUCKS
APTON, MD, JEFFREY H	ALLEGHENY
AQUILINA, MD, CHARLES J	LUZERNE
AQUINO, MD, EDWIN A	DAUPHIN
AQUINO, MD, JOSE HERNANI T	ALLEGHENY
ARAI, MD, YOSHIO	ALLEGHENY
ARANEDA, MD, LUIS O	BLAIR
ARANGIO, MD, GEORGE A	LEHIGH
ARANO, MD, LEONARDO V	MONTGOMERY
ARASTU, MD, MOHAMMAD I	NORTHAMPTON
ARAVABHUMI, MD, SRINIVAS	PHILADELPHIA
ARAVENA, MD, ERNESTO B	ALLEGHENY
ARAYA, MD, CLETO U	ALLEGHENY
ARAYA, MD, FERNANDO	LUZERNE
ARBITMAN, MD, MICHAEL	BLAIR
ARBOGAST JR, MD, JOHN W	UNION
ARBOGAST SR, MD, JOHN W	UNION
ARCE, MIGUEL A	STUDENT
ARCH JR, MD, FRANCIS J	ALLEGHENY
ARCHIBOLD, MD, RONALD C	PHILADELPHIA
ARDITO, MD, JOSEPH M	CHESTER
ARENA, MD, SEBASTIAN	ALLEGHENY
ARES, MD, NILDA E	LEBANON
ARETZ, MD, THOMAS E	CAMBRIA
AREVALO, MD, FERNANDO L	ALLEGHENY
ARGENIO, MD, SANDRA L	MONTOUR
ARGENTINE JR, MD, ROBERT P	ALLEGHENY
ARGER, MD, PETER H	PHILADELPHIA
ARGIRES, MD, JAMES P	LANCASTER
ARIAS, MD, JOANNA D	MONTOUR
ARILLOTTA, MD, CLYDE	ALLEGHENY
ARISUMI, MD, DAVID N	ALLEGHENY
ARISUMI, MD, SUSAN K	MONTOUR
ARKOOSH, MD, VALERIE A	PHILADELPHIA
ARLUK, MD, JUDITH I	ALLEGHENY
ARMANIOUS, MD, ADEL W	WESTMORELAND
ARMAO, MD, JOSEPH J	DELAWARE
ARMEN, MD, ROBERT N	ALLEGHENY
ARMENTI, MD, FREDERICK R	PHILADELPHIA
ARMENTO, MD, DONALD F	PHILADELPHIA
ARMFIELD III, MD, SAMUEL L	ALLEGHENY
ARMISTEAD, MD, THOMAS A	PHILADELPHIA
ARMITAGE, MD, HARRY V	DELAWARE
ARMOUR, DO, THOMAS F	MERCER
ARMOUR, MD, WILLIAM S	PHILADELPHIA
ARMSTEAD, PHYLLIS	STUDENT
ARMSTRONG, MD, B IRENE	ELK/CAMERON
ARMSTRONG, MD, DELILAH	DAUPHIN
ARMSTRONG, MD, JACK L	DAUPHIN
ARMSTRONG, MD, THOMAS A	MONTGOMERY
ARNAO, MD, JAMES	PHILADELPHIA
ARNDT, MD, JAMES L	BERKS
ARNER, MD, RAYMOND H	NORTHAMPTON
ARNHEIM, MD, FALK K	ALLEGHENY
ARNOLD, MD, JOHN J	CLEARFIELD
ARNOLD, MD, LAURA S	ALLEGHENY
ARNOLD, DO, WAYNE V	MONTGOMERY
ARNONE, DO, JAMES G	PHILADELPHIA
ARNOUK, MD, NABIL T	JEFFERSON
ARONICA, MD, MICHAEL J	LACKAWANNA
ARONOFF, MD, ROBERT D	DAUPHIN
ARONOW, MD, ELISABETH A	PHILADELPHIA
ARONSON, MD, JEROLD M	PHILADELPHIA
ARONSON, MD, MORTON L	ALLEGHENY
ARONSON, MD, SUSAN S	PHILADELPHIA
ARONSTAM, MD, ROBERT H	BRADFORD
ARORA, MD, MANJU	DELAWARE
ARORA, MD, RAMESH	CUMBERLAND
ARORA, MD, SAT P	DELAWARE
ARORA, MD, SUBHASH C	LACKAWANNA
AROUH, MD, ALBERT	DELAWARE
ARROW, DO, BEREL B	LANCASTER
ARSHT, DO, DAVID B	DELAWARE
ARSHT, MD, EDWIN D	DELAWARE
ARTHUR, MD, JAMES S	MCKEAN
ARTHUR, MD, KENNETH R	LANCASTER
ARTIS, MD, CATHY J	ALLEGHENY
ARTUSO, MD, FRANK B	ALLEGHENY
ARTUSO, MD, JAMES D	LANCASTER
ARUMUGARAJAH, MD, KANAGASABAPATHY	ADAMS
ASBELL, MD, SUCHA O	PHILADELPHIA
ASCANIO JR, MD, GUIDO J	BERKS
ASEEM, MD, WALI M	JEFFERSON
ASH, MD, S RUSSELL	MONTGOMERY
ASHBAUGH, STEPHANIE J	STUDENT
ASHBAUGH, MD, WILLIAM H	BUTLER
ASHBY, MD, JOHN D	FRANKLIN
ASHBY, THOMAS C	STUDENT
ASHMAN, MD, GEORGE S	CAMBRIA
ASHOK, MD, PUDUCHERI S	ALLEGHENY
ASHWORTH, MD, HALBERT E	BERKS
ASKAR, MD, F	PHILADELPHIA
ASKIN, MD, RALPH J	ALLEGHENY
ASKIN, MD, STANLEY R	PHILADELPHIA
ASKINAS, MD, ALAN M	CHESTER
ASLAM, MD, AZAR	CRAWFORD
ASLAM, MD, MOHAMMAD	SCHUYLKILL
ASLAM, MD, MOHAMMED	SOMERSET
ASMAN, MD, BARRY J	ALLEGHENY
ASO, MD, ORLANDO A	CARBON
ASPILI, MD, CONCEPCION S	PHILADELPHIA
ASPINALL, MD, ALAN R	WESTMORELAND
ASSANASEN, MD, BENJA V	WESTMORELAND
ASSANASEN, MD, CHARIN	WESTMORELAND
ASTA, LISA M	STUDENT
ASTARITA, MD, SALVATORE J	LANCASTER
ASTHANA, MD, SHOBHA	ALLEGHENY
ASTROFF, MD, MATTHEW R	CHESTER
ATHANI, MD, VIJAY S	ALLEGHENY
ATKIN, MD, DAVID H	ALLEGHENY
ATKINS, MD, JOHN L	YORK
ATKINS, MD, ROBERT M	YORK
ATKINS, MD, WILLIAM R	CHESTER
ATKINS JR, MD, JOSEPH P	PHILADELPHIA
ATKINS JR, MD, WILLIAM R	MONTGOMERY
ATKINSON, MD, BARBARA F	PHILADELPHIA
ATKINSON, MD, CHARLES A	STUDENT
ATKINSON, MD, DONALD P	ALLEGHENY
ATKINSON, MD, JEFFREY E	ALLEGHENY
ATKINSON, MD, NOLAN N	MONTGOMERY
ATKINSON, PAMELA A	STUDENT
ATTIPOE, MD, NOBEL D	PHILADELPHIA
ATWELL, MD, MARGARET S	BERKS
ATWELL, MD, ROBERT B	ALLEGHENY
ATWELL SR, DO, GRANT E	SOMERSET
AUCH, MD, ELLA M	NORTHAMPTON
AUCHENBACH, MD, RALPH C	ALLEGHENY
AUDAY, MD, JOSE H	PHILADELPHIA
AUERBACH, MD, HERMAN L	LUZERNE
AUERBACH, DO, JEFFREY C	WAYNE/PIKE
AUERBACH, MD, MARK H	NORTHAMPTON
AUERBACH, DO, ROBERT S	PHILADELPHIA
AUGELLI-HODOR, DO, LINDA P	NORTHAMPTON
AUGSBURGER, MD, JAMES J	PHILADELPHIA
AULT, GLENN T	STUDENT
AURAND, MD, ELEANOR M	MIFFLIN/JUNI
AURE, MD, HORACIO S	ALLEGHENY
AURE, MD, ISABEL R	ALLEGHENY
AURITT, MD, WILLIAM A	MONTGOMERY
AUSTIN, MD, EDWARD M	ALLEGHENY
AUSTIN JR, MD, CHARLES B	DAUPHIN
AUSTRIAN, MD, ROBERT C	PHILADELPHIA
AUTERI, MD, ANTHONY G	LEHIGH
AVANCENA, MD, EDGARDO P	MONTGOMERY
AVART, DO, HERBERT	DELAWARE
AVEDISSIAN, MD, MICHAEL G	BERKS
AVELLA, MD, BERARD N	BERKS
AVELLA, MD, DAVID P	CHESTER
AVELLINO, MD, JOSEPH D	PHILADELPHIA
AVENIA, MD, RONALD J	COLUMBIA
AVERBACH, DAVID H	STUDENT
AVERSA, MD, NICHOLAS	PHILADELPHIA
AVERSA, THADDEUS M	STUDENT
AVERY, MD, ANDREA D	ALLEGHENY
AVERY, MD, CHARLENE	BERKS
AVILA, MD, PEDRO C	PHILADELPHIA
AVNER, MD, DAVID L	GREENE
AWAD, MD, LATIF L	MONTOUR
AWAN, MD, IHSAN H	ALLEGHENY
AWAN, MD, RASHID A	CAMBRIA
AXELROD, MD, BUDD S	PHILADELPHIA
AXELROD, MD, JANICE H	ALLEGHENY
AXELROD, MD, LAWRENCE S	MONTGOMERY
AXELROD, DO, NORMAN M	LANCASTER
AXELROD, MD, RANDI A	PHILADELPHIA
AXELROD, MD, RITA S	PHILADELPHIA
AXELSON, MD, ALAN A	ALLEGHENY
AYALA, MD, KALIPRASAD N	DELAWARE
AYASSO, MD, M SAMIR	ALLEGHENY
AYDIN, MD, ABED A	JEFFERSON
AYERLE, MD, ROBERT S	PHILADELPHIA
AYERS, MD, LLOYD R	BLAIR
AYERS JR, MD, WILLIAM H	DELAWARE
AYLWARD, MD, JOHN J	CHESTER
AYOUB, MD, WILLIAM T	MIFFLIN/JUNI
AYRES, MD, WILLIAM W	FAYETTE
AZAD, MD, ARMIN	PHILADELPHIA
AZAR, MD, ALBERT A	YORK
AZAR, MD, MICHAEL J	ALLEGHENY
AZAR, MD, REZA R	BUCKS
AZCONA, MD, OSCAR C	WASHINGTON
AZEEZ, MD, SALEEM A	PHILADELPHIA
AZER, MD, MAGDI S	CAMBRIA
AZHAR, MD, GOHAR	ALLEGHENY
AZIZ, MD, ABDULRAB	ALLEGHENY
AZIZKHAN, MD, REZA G	DAUPHIN
AZURIN, MD, ARTURO C	ALLEGHENY

B

BABB, MD, TERRENCE E	TIOGA
BABIN, MD, ROMAN A	ELK/CAMERON
BABINECZ, MD, JOHN M	CHESTER
BABINS, MD, DAVID M	ERIE
BACAK, MD, JOSEPH F	NORTHAMPTON
BACAL, DARRON A	STUDENT
BACASTOW, MD, MERLE S	YORK
BACCASH, MD, PATRICIA D	PHILADELPHIA
BACESKI, MD, DEBORAH A	SOMERSET
BACHARACH, MD, BENJAMIN	PHILADELPHIA
BACHARACH, MD, MATTHEW D	LANCASTER
BACHMAN, MD, WILLIAM H	LANCASTER
BACKENSTOSE, MD, DANIEL L	DAUPHIN
BACKES, MD, CELSO L	POTTER
BACKUP, MD, CLIFFORD E	PHILADELPHIA
BACON, MD, GEOFFREY W	ALLEGHENY
BACON, MD, RICHARD W	LANCASTER
BADAMO, MD, FRANCIS P	JEFFERSON
BADARACCO, MD, MARIE R	COLUMBIA
BADAWI, MD, RADWAN A	LACKAWANNA
BADAYOS, MD, ALICIA P	MONTGOMERY
BADER, KAREN M	STUDENT
BADIALI, MD, S CHARLES	WASHINGTON
BADMAN, MD, DENNIS S	TIOGA
BADOLATO, MD, DAVID J	MONTGOMERY
BADOSA, MD, FRANCISCO	PHILADELPHIA
BADWAY, MD, DAVID M	ALLEGHENY
BAER, MD, GERALD R	LANCASTER
BAER, MD, HARRY M	PHILADELPHIA
BAER, MD, MICHAEL T	DAUPHIN
BAER, MD, SAMUEL	PHILADELPHIA
BAERTL, MD, JUAN M	YORK
BAFFONI JR, MD, ALBERT D	ALLEGHENY
BAGDORF, MD, ROBERT	INDIANA
BAGHAI-NAIINI, MD, PARVIZ	ALLEGHENY
BAGLEY, MD, DEMETRIUS H	PHILADELPHIA
BAHIA, MD, JINAN O	DAUPHIN
BAHL, MD, MOHINDER M	ALLEGHENY
BAHL, MD, VIJAY K	ALLEGHENY
BAHLER, MD, EILEEN	WESTMORELAND
BAIKADI, MD, MADHAVA	LACKAWANNA
BAILER, DO, ALAN S	MONTGOMERY
BAILES JR, MD, JULIAN E	ALLEGHENY
BAILEY, MD, DOMINIQUE R	NORTHAMPTON
BAILEY, MD, STEPHEN R	ALLEGHENY
BAILEY, MD, THOMAS M	NORTHAMPTON
BAILEY, MD, WILLIAM R	ALLEGHENY
BAILEY III, DO, JOHN H	CRAWFORD
BAILEY JR, MD, JOHN H	CRAWFORD
BAILEY JR, MD, ROBERT S	MONTGOMERY
BAILEY JR, DO, WILLIAM H	ALLEGHENY
BAILLIE, MD, JON-ERIC	ALLEGHENY
BAILON, MD, ALEXANDER G	ALLEGHENY
BAIO, MD, MICHAEL V	DELAWARE
BAIR, MD, JEFFREY F	MONROE
BAIR, MD, ROBERT C	TIOGA
BAIR, MD, VICTOR W	WASHINGTON
BAIR, MD, WILLIAM L	ALLEGHENY
BAIRD, MD, EDWARD F	LANCASTER
BAIRD, MD, JAMES W	ALLEGHENY
BAIRD, MD, ROBERT M	MONROE
BAJAJ, MD, RAJIV K	LACKAWANNA
BAJWA, MD, SURINDER S	WESTMORELAND
BAKER, MD, BARRIE G	PHILADELPHIA
BAKER, MD, CAROL C	ALLEGHENY
BAKER, MD, DAVID C	LEHIGH
BAKER, MD, DAVID G	LANCASTER
BAKER, MD, DONALD J	PHILADELPHIA
BAKER, MD, EVERETT M	ALLEGHENY
BAKER, MD, GRAEME C	ERIE
BAKER, MD, JEFFREY H	CENTRE
BAKER, MD, KAREN S	ALLEGHENY
BAKER, MD, KENNETH M	MONTOUR
BAKER, MD, MARK S	CENTRE
BAKER, MD, MARVIN P	BUTLER
BAKER, MD, MICHAEL P	MONTOUR
BAKER, MD, R J	ALLEGHENY
BAKER, RANDOLPH M	STUDENT
BAKER, MD, ROBERT H	MERCER
BAKER, MD, ROBERT L	ALLEGHENY
BAKER, MD, ROY F	CENTRE
BAKER, DO, TERENCE R	BERKS
BAKER, MD, THOMAS E	LUZERNE
BAKER, MD, WALTER J	ALLEGHENY
BAKER II, DO, ROBERT L	ALLEGHENY
BAKER JR, MD, ARTHUR G	DELAWARE
BAKER JR, MD, GEORGE W	FRANKLIN
BAKEWELL, MD, FRANK S	WASHINGTON
BAKSHI, MD, KALIND R	PHILADELPHIA
BAKSHI, MD, KINNARI K	BUCKS
BAKTH, MD, SHAMSHER	ALLEGHENY
BALABAN, MD, DONALD J	PHILADELPHIA
BALARAMAN, MD, GOVINDACHETTY	FRANKLIN
BALASH, MD, WILLIAM R	ARMSTRONG
BALASUBRAMANIAM, MD, MANI	FAYETTE
BALASUBRAMANIAN, MD, EASWARAN	PHILADELPHIA
BALCER, MD, LAURA J	PHILADELPHIA
BALCHANDANI, MD, RAJKUMAR S	PHILADELPHIA
BALCITA, MD, ARTHUR L	WESTMORELAND
BALCITA JR, MD, ANGEL S	WESTMORELAND
BALDASSANO, MD, ROBERT N	MONTOUR
BALDASSARRE, MD, JAMES S	PHILADELPHIA
BALDECK, MD, ANDREA M	PHILADELPHIA
BALDERACH, MD, RONALD R	LAWRENCE
BALDERSTON, MD, RICHARD A	PHILADELPHIA
BALDIA, MD, LIVEO B	COLUMBIA
BALDWIN, ROBERT C	STUDENT
BALDWIN, MD, THOMAS M	BEAVER
BALDYS, MD, JAMES S	LYCOMING
BALEANU-MALLOZZI, MD, RALUCA I	LANCASTER
BALES, MD, CHARLES R	ERIE
BALI, MD, AJAY K	LUZERNE
BALIN, MD, ARTHUR K	DELAWARE
BALIN, MD, BENJAMIN R	DELAWARE
BALINT, MD, BART W	ERIE
BALISTOCKY, MD, MARVIN H	MONTGOMERY
BALK, MD, PHILLIP	ALLEGHENY
BALKMAN, MD, KAREN M	ALLEGHENY
BALL, DO, DAVID J	COLUMBIA
BALLANTYNE, MD, JAMES V	ALLEGHENY
BALLARD, MD, IAN M	MONTGOMERY
BALLEK, MD, RONALD E	PHILADELPHIA
BALLENTINE, MD, GEORGE N	LYCOMING
BALLENTINE, MD, RUDOLPH M	WAYNE/PIKE
BALLO, MD, FRANCES S	MONTOUR
BALLS, MD, KENT F	MONTGOMERY
BALMASEDA, MD, OFELIA B	PHILADELPHIA
BALOCH, MD, ZUBAIR W	PHILADELPHIA
BALOG, MD, BALINT	DAUPHIN
BALOGH JR, MD, ROBERT J	LEBANON
BALOURIS, MD, CHRIST A	ALLEGHENY
BALSAMO, MD, ANTHONY J	PHILADELPHIA
BALSBAUGH, MD, GEORGE T	DAUPHIN
BALSHI, MD, JAMES D	NORTHAMPTON
BALSHI, MD, STEPHEN F	NORTHAMPTON
BALTAROWICH, MD, OKSANA H	PHILADELPHIA
BALTZ, MD, RICHARD D	DAUPHIN
BALTZELL, MD, WILLIAM H	PHILADELPHIA
BALUH, MD, HOPE M	SOMERSET
BALZ, MD, THOMAS P	MONTOUR
BAMBERGER, MD, GRANT W	CHESTER
BAMBERGER, MD, JOHN A	LEBANON
BAMONT, MD, ANTHONY J	PHILADELPHIA
BAMONTE, MD, EDWARD L	ALLEGHENY
BANACH, MICHAEL J	STUDENT
BANCROFT, MD, EDITH D	MONTGOMERY
BANCROFT, MD, URSULA F	PHILADELPHIA
BANDA, MD, MARY C	DAUPHIN
BANDALA, MD, LEONARD C	NORTHAMPTON
BANDARANAYAKE, MD, NIRANTHA M	WESTMORELAND
BANDARANAYAKE, MD, PICHING	ALLEGHENY
BANDERA, MD, PETER B	MONTGOMERY
BANDINI JR, MD, PAUL J	PHILADELPHIA
BANDS JR, MD, ROY E	CUMBERLAND
BANE, MD, DENIS M	SCHUYLKILL
BANERJI, SANJAY	STUDENT
BANEY JR, MD, CHARLES M	BERKS
BANK, MD, R STANLEY	DAUPHIN
BANKA, MD, REENA S	PHILADELPHIA
BANKA, MD, VIDYA S	PHILADELPHIA
BANKACI, MD, MURAT	WESTMORELAND
BANMILLER, MD, JAMES D	MONTGOMERY
BANNER, MD, RICHARD N	MONTGOMERY
BANNER, MD, RONALD S	PHILADELPHIA
BANNING, DO, RICHARD J	SCHUYLKILL
BANNISTER, MD, KYRA H	BRADFORD
BANNISTER JR, MD, WILLIAM B	LAWRENCE
BANNON, MD, CHARLES J	LACKAWANNA
BANNON, MD, JOSEPH P	PHILADELPHIA
BANOGON, MD, MARIETTA A	DAUPHIN
BANQUERIGO, MD, ELDINE A	BERKS
BANSAL, MD, SURENDRA K	ALLEGHENY
BANSBACH, MD, JEAN M	PHILADELPHIA
BANSBACH, MD, WILLIAM A	PHILADELPHIA
BANSIDHAR, MD, BHADRASINE	BEAVER
BANTLY, MD, VICTOR S	CAMBRIA
BANTOM III, MD, WALTER E	PHILADELPHIA
BANZHOFF, MD, GORDON K	DAUPHIN
BAQUERO-BUENO, MD, MARIO R	WASHINGTON
BAR, MD, ALLEN H	PHILADELPHIA
BARAD, MD, ROXANA F	ALLEGHENY
BARAFF, MD, ROBERT	ALLEGHENY
BARAKAT, MD, ADEL R	LACKAWANNA
BARAKAT, MD, OMAR	PHILADELPHIA
BARAN, MD, ERNEST M	MONTGOMERY
BARAN, MD, JAMES J	ALLEGHENY
BARAN, MARK S	STUDENT
BARANSKI, MD, EDWARD J	ADAMS
BARATTA, MD, PASQUALE D	WAYNE/PIKE
BARATZ, MD, BURTON H	PHILADELPHIA
BARBA III, MD, WILLIAM P	BUCKS
BARBAREVECH, CHRISTOPHER A	STUDENT
BARBER, MD, JAMES J	ALLEGHENY
BARBER, MD, JOHN C	ALLEGHENY
BARBER, MD, JOHN V	WESTMORELAND
BARBER, MD, JOSEPH C	ERIE
BARBER, MD, LEE A	PHILADELPHIA
BARBER, MD, MARGARET	PHILADELPHIA
BARBERA, CHARLES F	STUDENT
BARBOT, MD, DONNA J	PHILADELPHIA
BARCH, MD, FRANK J	CHESTER
BARCLAY, MD, CLAYTON C	SCHUYLKILL
BARCLAY JR, MD, CLAYTON C	MONTGOMERY
BARD, MD, JOSEPH L	MONTGOMERY
BARDELL, MD, CRAIG R	SCHUYLKILL
BARDELLA, MD, INIS J	CAMBRIA
BARDZIL, MD, JOSEPH W	WASHINGTON
BARENBAUM, MD, DANIEL H	PHILADELPHIA
BARENBERG, MD, PAUL A	CHESTER
BARG, MD, RONALD B	MONTGOMERY
BARILLA, MD, DONALD E	LEHIGH
BARKE, MD, JAMES N	BERKS
BARKER, MD, CLYDE F	PHILADELPHIA
BARKER, MD, RICHARD G	PHILADELPHIA
BARLEY, MD, SAMUEL B	JEFFERSON
BARLOW JR, MD, ROBERT A	PHILADELPHIA
BARMADA, MD, BICHER	ALLEGHENY
BARNA, MD, NICHOLAS J	MONTOUR
BARNABY JR, MD, ARTHUR J	PHILADELPHIA
BARNES, MD, ANNE U	PHILADELPHIA
BARNES, MD, BARBARA E	ERIE
BARNES, MD, BEN C	LEHIGH
BARNES, MD, DENICE M	BUCKS
BARNES, MD, W STEPHEN	CENTRE
BARNES, MD, WILLIAM J	ALLEGHENY
BARNES, MD, WILLIAM T	CENTRE
BARNES, MD, WILLIS C	LACKAWANNA
BARNES II, MD, ARTHUR E	WESTMORELAND
BARNETT, MD, ALAN J	ALLEGHENY
BARNETT, MD, CHARLES F	PHILADELPHIA
BARNETT, MD, RONALD B	MONTGOMERY
BARNETT, MD, STEWART D	PHILADELPHIA
BARNETT-RICO, MD, MARIAN	BUTLER
BARNHART, MD, JONATHAN L	ALLEGHENY
BARNHOUSE, MD, DAVID H	ALLEGHENY
BARNICLE, MD, DANIEL J	INDIANA
BARNICLE, MD, MARYANNE	INDIANA
BARNOSKI, MD, JOHN F	DAUPHIN
BARNWELL, MD, ANNE-BATTISTE	ERIE
BAROLAT-ROMANA, MD, GIANCARLO	PHILADELPHIA
BARON, MD, JOHN	ALLEGHENY
BARON, MD, RAYMOND C	PHILADELPHIA
BARON, MD, RICHARD J	PHILADELPHIA

BARON, MD, SCOTT L	ALLEGHENY
BARON JR, MD, ANDREW J	LACKAWANNA
BARONE, MD, ANTHONY	LEHIGH
BARONE, MD, FRANCES A	BUCKS
BARONE, MD, SAMUEL F	ALLEGHENY
BARR, MD, GARY A	ALLEGHENY
BARR, MD, GAVIN C	NORTHAMPTON
BARR, MD, HARRY J	MONTGOMERY
BARR, DO, LAWRENCE I	PHILADELPHIA
BARR, LYNN D	STUDENT
BARR, MD, RICHARD G	DELAWARE
BARR, MD, V WARD	LANCASTER
BARR JR, MD, JAMES H	ALLEGHENY
BARRAS, MD, DAVID I	LUZERNE
BARRASSE, MD, LINDA D	LACKAWANNA
BARRER, MD, MITCHELL J	BUCKS
BARRER, MD, STEVEN J	MONTGOMERY
BARRETT, MD, GEORGE S	NORTHAMPTON
BARRETT, MD, JAMES P	BERKS
BARRETT, MD, JOHN L	ALLEGHENY
BARRETT, MD, MICHAEL J	PHILADELPHIA
BARRETT, MD, ROBYN LERNER	PHILADELPHIA
BARRETT, MD, STEPHEN J	LEHIGH
BARRETT, MD, WILLIAM A	ALLEGHENY
BARRETTE, MD, ROGER R	WASHINGTON
BARRINGER, MD, LYDIA R	PHILADELPHIA
BARRIOS, MD, MARIO F	BERKS
BARRIS, MD, BRUCE J	BUCKS
BARRIST, MD, ELLIS M	PHILADELPHIA
BARRY, MD, BRENDA M	PHILADELPHIA
BARRY, MD, KEVIN P	PHILADELPHIA
BARRY, MD, WILLIAM E	PHILADELPHIA
BARRY, MD, WILLIAM J	CHESTER
BARSANTI, MD, RONALD G	DAUPHIN
BARSKY, MD, DIANE L	PHILADELPHIA
BARSKY, DO, HOWARD EDWIN	PHILADELPHIA
BARSOUM, MD, ADIB H	WESTMORELAND
BARSZCZOWSKI JR, MD, PETER J	LAWRENCE
BARTEAUX, MD, JOHN W	ERIE
BARTELT, DO, MATTHEW S	NORTHAMPTON
BARTENHAGEN, MD, NICHOLAS H	BRADFORD
BARTGES, MD, JOHN D	LANCASTER
BARTH, LINDA J	STUDENT
BARTHO, MD, BLAINE F	PERRY
BARTLE JR, MD, HARVEY	MONTGOMERY
BARTLETT, MD, DAVID L	PHILADELPHIA
BARTLETT, MD, GLEN S	DAUPHIN
BARTLETT, MD, SCOTT P	PHILADELPHIA
BARTLETT JR, MD, FREDERICK H	MONTGOMERY
BARTLOW, MD, WILLIAM P	LYCOMING
BARTMAN, THOMAS	STUDENT
BARTOLANZO, MD, ROBERT A	BUCKS
BARTOLET, LORA L	STUDENT
BARTOLET, MD, TERRY L	NORTHAMPTON
BARTOLOZZI, MD, MARIA A	PHILADELPHIA
BARTON, MD, F JANE	DAUPHIN
BARTON, MD, JAMES C	FRANKLIN
BARTON, MD, JOHN O	DAUPHIN
BARTON, MD, ROBERT L	LEBANON
BARTONE, MD, FRANCIS F	MONTOUR
BARTOS, MD, JOSEPH E	NORTHAMPTON
BARTOS, MD, SYLVIA A	WASHINGTON
BARTOSIK, MD, DELPHINE B	PHILADELPHIA
BARTUSKA, MD, DORIS G	PHILADELPHIA
BARTUSKA, MIA C	STUDENT
BARUA, MD, SUBRATA P	WESTMORELAND
BARUSEWYCZ, MD, SR MARIA N	PHILADELPHIA
BARZEL, MD, EYAL	PHILADELPHIA
BARZYK, MD, PETER P	ERIE
BASALA, DO, PHILIP A	BLAIR
BASARAB, MD, ROBERT M	LANCASTER
BASEMAN, MD, ALAN S	BUCKS
BASEMAN, MD, DEBRA M	PHILADELPHIA
BASESKI, DO, THERESA M	LUZERNE
BASH, MD, EVAN K	DELAWARE
BASHARA, MD, THOMAS J	LAWRENCE
BASHEIN, DO, HAL J	PHILADELPHIA
BASHLINE, DO, BRUCE S	DAUPHIN
BASHLINE, MD, DON L	MERCER
BASHLINE, DO, H WOODROW	MERCER
BASHORE JR, MD, ROBERT M	LANCASTER
BASILE, MD, JOSEPH	BLAIR
BASKA, MD, JOHN K	BEAVER
BASOM, MD, DONALD E	MIFFLIN/JUNI
BASRA, MD, RAJINDER K	DAUPHIN
BASSALY, MD, RIFAAT R	LAWRENCE
BASSETT, MD, JAMES G	PHILADELPHIA
BASSILIOS, MD, FOUAD A	ALLEGHENY
BAST, MD, WILLIAM R	ADAMS
BASTIAN, MD, GRACE A	PHILADELPHIA
BASTIAN, MD, JAMES R	LYCOMING
BASTING, MD, GREGORY G	LACKAWANNA
BATCHELDER, MD, BARRON M	BERKS
BATCHELET, DO, RICHARD B	DELAWARE
BATCHELOR, MD, ALLISON J	BEAVER
BATES, MD, JAMES S	MONTOUR
BATES JR, MD, OLLICE	MONTOUR
BATHRICK, MD, CHARLES E	ERIE
BATIPPS JR, MD, PERCY O	DELAWARE
BATOFF, MD, MILTON A	PHILADELPHIA
BATOK, MD, GARY R	LUZERNE
BATORY, MD, KATHERINE H	CENTRE
BATRA, MD, PREET M	PHILADELPHIA
BATTAFARANO, MD, LEONARD A	PHILADELPHIA
BATTAFARANO, MD, NICHOLAS C	CHESTER
BATTAGLIA, MD, DAVID R	MONTGOMERY
BATTAGLIA, MD, MARIANO F	ALLEGHENY
BATTERTON, MD, THOMAS D	PHILADELPHIA
BATTISTA, MD, FRANK J	DAUPHIN
BATTLE, MD, WILLIAM M	PHILADELPHIA
BATTS JR, MD, JAMES A	PHILADELPHIA
BATZER, MD, FRANCES R	PHILADELPHIA
BAUER, MD, FRANK L	ALLEGHENY
BAUER, MD, JAMES E	INDIANA
BAUER, MD, JAMES E	ARMSTRONG
BAUER, MD, ROBERT L	LEBANON
BAUER, MD, THOMAS L	YORK
BAUER, MD, WILLIAM F	ALLEGHENY
BAUERSFELD, MD, B RICHARD	ALLEGHENY
BAUM, MD, EDGAR S	LEHIGH
BAUM, MD, JEFFREY A	ALLEGHENY
BAUM, JONATHAN D	STUDENT
BAUM, MD, NEIL B	WESTMORELAND
BAUM, MD, RICHARD A	PHILADELPHIA
BAUM, MD, SHELDON F	DELAWARE
BAUM-BARVIE, MD, ALICIA	WESTMORELAND
BAUMAN, MD, DOROTHY H	ALLEGHENY
BAUMAN, DO, JOHN M	ERIE
BAUMAN, MD, THOMAS W	FAYETTE
BAUMANN, MD, BRENDA K	LUZERNE
BAUMANN, MD, THOMAS L	LUZERNE
BAUMGARDNER, MD, JAMES E	PHILADELPHIA
BAUMGARTEL, MD, IRA E	ALLEGHENY
BAUMWELL, MD, IVAN A	ALLEGHENY
BAURER, MD, FREDERIC M	PHILADELPHIA
BAUSCH, MD, ANDREW N	LEHIGH
BAUSCH, MD, RICHARD D	LEHIGH
BAUSCH JR, MD, FREDERICK R	LEHIGH
BAUTISTA, MD, PRIMO V	WESTMORELAND
BAVER, MD, GEORGE A	MONTGOMERY
BAXLEY, MD, MICHAEL N	ALLEGHENY
BAXTER, MD, JOHN A	MONTOUR
BAXTER, MD, LOUIS E	MONTOUR
BAY, NICHOLAS W	STUDENT
BAYANI JR, MD, ELADIO Y	WESTMORELAND
BAYER, DO, JAY D	FRANKLIN
BAYER, MD, JOSEPH F	WASHINGTON
BAYRI, MD, MEHMET F	LEHIGH
BAYUK, MD, JOHN D	BEAVER
BAYUK, MD, JULIAN M	MONTGOMERY
BAZARGANI, MD, TAWOOS	MONTGOMERY
BAZEWICZ, MD, ROBERT A	LEBANON
BAZMI, MD, HASSAN	ALLEGHENY
BAZMI, MD, NEPTUNE K	ALLEGHENY
BAZRON, MD, HERBERT	ALLEGHENY
BAZYLAK, MD, ROBERT A	CRAWFORD
BAZZOUI, MD, WIDAD	MCKEAN
BEACHER JR, MD, GEORGE W	LANCASTER
BEACHLER, MD, JOHN S	ALLEGHENY
BEACHLEY, MD, MICHAEL C	ALLEGHENY
BEACHY, MD, IVAN E	CUMBERLAND
BEACHY, MD, STANLEY C	CUMBERLAND
BEALE, MD, BENJAMIN R	DAUPHIN
BEALE, DO, EILEEN P	MONTGOMERY
BEALER, MD, JOHN D	NORTHAMPTON
BEALL, MD, SANDRA C	LYCOMING
BEAN, MD, CARL B	BUTLER
BEAN, MD, GEORGE J	MONTOUR
BEANE, MD, HOWARD C	DAUPHIN
BEARDSLEY, SHANNON L	STUDENT
BEARDWOOD, MD, DONALD M	MONTGOMERY
BEASTON-WIMMER, PATRICIA R	STUDENT
BEATON, DO, DAVID L	ERIE
BEATTIE, MD, JAMES R	PHILADELPHIA
BEATTY, MD, ALBERT C	PHILADELPHIA
BEATTY, MD, RICHARD W	ALLEGHENY
BEAUCHAMP, MD, JEFFREY T	PHILADELPHIA
BEAUCHAMP JR, MD, EUGENE W	PHILADELPHIA
BEAUDREAU, MD, DAVID G	ALLEGHENY
BEAUGARD, MD, MARK E	CHESTER
BEAUSANG, MD, THOMAS	SCHUYLKILL
BEAVEN, MD, BARRY J	YORK
BEAVER, MD, WARREN J	ERIE
BEBB, MD, DONALD R	MONTGOMERY
BECERRA-CABAL, MD, LUIS I	MONTGOMERY
BECHTEL, MD, ROBERT T	DAUPHIN
BECK, MD, AARON T	PHILADELPHIA
BECK, MD, ALLAN G	PHILADELPHIA
BECK, MD, BONNY L	MONTOUR
BECK, MD, CHRISTINE H	NORTHAMPTON
BECK, MD, DONALD E	MERCER
BECK, MD, GERALD	ERIE
BECK, MD, JAN	BRADFORD
BECK, JEFFREY A	STUDENT
BECK, DO, JONATHAN E	MONTGOMERY
BECK, MD, LAURENCE H	MONTOUR
BECK, MD, ROBERT H	HUNTINGDON
BECK, MD, RONALD C	ALLEGHENY
BECK, MD, SIDNEY	PHILADELPHIA
BECK, MD, SYLVIA R	PHILADELPHIA
BECK, TRACI P	STUDENT
BECK, MD, WILLIAM C	BRADFORD
BECK, MD, WILLIAM R	CENTRE
BECKER, MD, BRUCE	COLUMBIA
BECKER, CARL E	STUDENT
BECKER, MD, IRWIN	PHILADELPHIA
BECKER, MD, JACK M	MONTGOMERY
BECKER, DO, JOHN C	LYCOMING
BECKER, MD, JOSEPH M	PHILADELPHIA
BECKER, MD, MARK J	ALLEGHENY
BECKER, MD, MARTIN S	NORTHAMPTON
BECKER, DO, MICHAEL A	DELAWARE
BECKER, MD, STEPHEN E	BLAIR
BECKER, MD, STEPHEN M	FRANKLIN
BECKER, MD, WARD G	BERKS
BECKLEY, MD, ROBERT F	LYCOMING
BECKMAN, DO, IRWIN	ALLEGHENY
BECKMAN, MD, ROBERT A	PHILADELPHIA
BECKMAN, MD, WILLIAM R	ADAMS
BECKWITH, MD, WILLIAM R	DELAWARE
BEDDINGS, MD, ALEJANDRO	BUCKS
BEDETTI, MD, CARLOS D	ALLEGHENY
BEDFORD, MD, RICHARD A	PHILADELPHIA
BEDGER JR, MD, RICHARD C	CLEARFIELD
BEDNAR, MD, JOHN M	PHILADELPHIA
BEDNAREK, MD, JOSEPH M	PHILADELPHIA
BEDNAREK, MD, THOMAS F	BRADFORD
BEDNARSKI, MD, JEFFREY J	ERIE
BEDNARZ, MD, LUCIAN P	STUDENT
BEDNARZ, MD, WALLACE W	LYCOMING
BEDRICK, MD, EDWARD L	PHILADELPHIA
BEDROSSIAN, MD, E HOWARD	DELAWARE
BEDROSSIAN JR, MD, EDWARD H	DELAWARE
BEDWELL, MD, SCOTT H	CRAWFORD
BEEBY, MD, JAMES L	ERIE
BEEKEY JR, MD, CYRUS E	YORK
BEEM, MD, JOHN W	BERKS
BEERMAN, MD, CURTIS A	CAMBRIA
BEERMAN, MD, HERMAN	PHILADELPHIA
BEERS, MD, KENNETH L	BLAIR
BEERS, MD, MICHAEL F	DELAWARE
BEETEL, MD, CHRISTOPHER J	BERKS
BEGG, MD, FRANK R	ALLEGHENY
BEGG, MD, RICHARD J	ALLEGHENY
BEGLEY, MD, CHRISTOPHER J	BLAIR
BEGUM, MD, DILWARA	ALLEGHENY
BEGUN, MD, JEROME H	LUZERNE
BEH, MD, WALTER P	MERCER
BEHAR, MD, ROBERT D	PHILADELPHIA
BEHLKE, MD, RICHARD T	LACKAWANNA
BEHREND, MD, BERNARD	PHILADELPHIA
BEHRENDT, MD, RICHARD P	ALLEGHENY
BEHUN, MD, JOSEPH M	ALLEGHENY
BEIDLER, MD, JON G	FRANKLIN
BEIDLER, LEANNE K	STUDENT
BEILER, MD, DAVID D	MONTOUR
BEITEL JR, MD, ROBERT J	LEHIGH
BEITLE, DAVID	STUDENT
BEITTEL JR, MD, CHARLES R	DAUPHIN
BEITZEL, MD, JAMES E	SOMERSET
BEIZER, MD, LAWRENCE H	PHILADELPHIA
BEKOE, MD, SETH	ALLEGHENY
BELAK, MICHELE M	STUDENT
BELASCO, MD, ROBERT N	MONTGOMERY
BELBER, MD, ARTHUR D	MONTGOMERY
BELFIGLIO, DO, STEPHEN F	PHILADELPHIA
BELICH, MD, STEPHEN C	BEAVER
BELK, MD, H DEAN	ALLEGHENY
BELKOFF, DO, KENNETH M	PHILADELPHIA
BELKOFF, DO, LAURENCE H	MONTGOMERY
BELL, MD, ELLA C	PHILADELPHIA
BELL, MD, H CRAIG	MONTGOMERY
BELL, MD, JAMES B	DELAWARE
BELL, KAREN A	STUDENT
BELL, MD, LAWRENCE D	BEAVER
BELL, MD, LOUIS D	PHILADELPHIA
BELL, MD, MICHAEL A	LEHIGH
BELL, MD, MICHAEL C	BEAVER
BELL, MD, RANDALL W	MONTGOMERY
BELL, MD, RICHARD T	BERKS
BELL, MD, ROBERT L	CHESTER
BELL, MD, STEPHEN T	LANCASTER
BELL, MD, STEVEN D	PHILADELPHIA
BELL, MD, THOMAS G	CLEARFIELD
BELL JR, MD, C RAY	LEBANON
BELL-THOMSON, MD, JOHN	PHILADELPHIA
BELLA, MD, PARALUMAN	BUTLER
BELLA, MD, ROMEO H	LAWRENCE
BELLANCA JR, MD, GUY L	WESTMORELAND
BELLER, MD, MARTIN L	PHILADELPHIA
BELLES, MD, TERRY A	LYCOMING
BELLIN, MD, HARVEY J	PHILADELPHIA
BELLIN, LISA S	STUDENT
BELLINGER, MD, E LEE	TIOGA
BELLIS, MD, JOHN A	CHESTER
BELLOWS, CHARLES F	STUDENT
BELLUS, MD, JOHN J	MONTGOMERY
BELMONT, MD, DONALD J	LEHIGH
BELMONT, MD, FRANK A	PERRY
BELMONT, MD, HERMAN S	PHILADELPHIA
BELMONT, MD, JONATHAN B	MONTGOMERY
BELMONT, MD, OWEN	PHILADELPHIA
BELOFF, MD, LOUIS	BUCKS
BELOVICH, MD, DEBBIE L	DAUPHIN
BELSON, MD, ARTHUR B	CHESTER
BELTZ, MD, WILLIAM R	LYCOMING
BEMILLER, MD, CARL	SCHUYLKILL
BEMIS, MD, CHARLES EASTMAN	PHILADELPHIA
BEN-MAIMON, MD, CAROLE S	PHILADELPHIA
BENACK, MD, ANDREA	PHILADELPHIA
BENACK, MD, CARL A	ALLEGHENY
BENCIE, MD, DAVID J	CAMBRIA
BENCKART, MD, DANIEL H	ALLEGHENY
BENDER, MD, BARRY L	CLINTON
BENDER, MD, BRUCE L	LEHIGH
BENDER, MD, BRUCE R	BEAVER
BENDER, MD, GIL	PHILADELPHIA
BENDER, DO, JOHN D	MONTGOMERY
BENDER, MD, JOSEPH	MONTGOMERY
BENDER, MD, RICHARD J	ALLEGHENY
BENDER, THOMAS M	STUDENT
BENDER, MD, WILLIAM A	FRANKLIN
BENDER JR, MD, FRANK C	DELAWARE
BENDERSKY, MD, GORDON	PHILADELPHIA
BENDITT, MD, MILTON BARRY	PHILADELPHIA
BENDITT, MD, PHILIP L	PHILADELPHIA
BENDIXEN, KARLYN A	STUDENT
BENDLIN, MD, ARNALDO	PHILADELPHIA
BENE, MD, CATHERINE H	YORK
BENECK, MD, STEPHEN M	PHILADELPHIA
BENEDETTO, DO, ANTHONY V	PHILADELPHIA
BENEDETTO, MD, ERNEST A	PHILADELPHIA
BENEDICT, MD, ALAN L	ALLEGHENY
BENEDICT, CATHERINE R	STUDENT
BENEDICT, MD, JOHN H	DAUPHIN
BENEDICT, MD, LINDA M	ALLEGHENY
BENES III, DO, FRANK J	ERIE
BENESKI, MD, DANIEL A	DELAWARE
BENGTSON, MD, CAROLYN R	POTTER
BENINATI, MD, DANIEL D	CHESTER
BENITEZ, MD, FRANCISCO W	BLAIR
BENJAMIN, MD, BONNA G	ALLEGHENY
BENJAMIN, MD, DAVID R	ERIE
BENJAMIN, MD, JOSEPH	BUCKS
BENJAMIN, MD, KENNETH W	PHILADELPHIA
BENKINNEY, MD, JAMES A	LUZERNE
BENKO, MD, STEPHEN T	CAMBRIA
BENKOVIC, MD, GREGORY W	MONTOUR
BENNER, MD, JOHN N	WYOMING
BENNER, MD, PRISCILLA J	MONTGOMERY
BENNER IV, MD, JOHN H	CHESTER
BENNETT, DO, DAVID J	BEAVER
BENNETT, MD, HUGH D	PHILADELPHIA
BENNETT, MD, JOEL A	PHILADELPHIA
BENNETT, MD, JOHN A	MONTGOMERY
BENNETT, MD, JOHN T	MONTGOMERY
BENNETT, MD, LEO L	ERIE
BENNETT, MD, PAULA R	WAYNE/PIKE
BENNETT, MD, RAYMOND L	SUSQUEHANNA
BENNETT, MD, RICHARD H	PHILADELPHIA
BENNETT IV, MD, JOSEPH S	CHESTER
BENNIGHOF, MD, DAVID C	BEAVER
BENOIT, MD, CHARLES H	MONTOUR
BENOIT, DO, RICHARD A	LUZERNE
BENOVITZ, MD, BURTON S	LUZERNE
BENSCOTER, DO, DAN T	MONTOUR
BENSER, MD, SUZANNE K C	PHILADELPHIA
BENSHOFF, MD, ALBERT M	CAMBRIA
BENSHOFF, MD, ARTHUR M	CAMBRIA
BENSIMHON, MD, GEORGES J	NORTHAMPTON
BENSON, MD, DAVID R	CENTRE
BENSON, MD, JOHN M	BUCKS
BENSON, MD, JOHN R	PHILADELPHIA
BENSON, MD, WILLIAM E	PHILADELPHIA
BENSY, MD, JOSEPH J	ALLEGHENY
BENTIVOGLIO, MD, LAMBERTO G	PHILADELPHIA
BENTLEY, MD, EUGENE A	CHESTER
BENTLEY, RHONDA M A	STUDENT
BENTON, MD, OWEN D	WASHINGTON
BENTZ, BRANDON G	STUDENT
BENTZ, MD, CHARLES R	MCKEAN
BENTZ, MD, MICHAEL S	DAUPHIN
BENTZ, MD, RALPH A	DAUPHIN
BENZ, MD, EDWARD J	NORTHAMPTON
BENZ, MD, ROBERT L	MONTGOMERY
BENZ, MD, THOMAS B	ALLEGHENY
BENZ JR, MD, GEORGE H	ALLEGHENY
BEPLER, MD, CHARLES R	DELAWARE
BERAN, MD, SAMUEL J	PHILADELPHIA
BERARDI, MD, RONALD S	WESTMORELAND
BERBA, MD, REGINA P	PHILADELPHIA
BERBERICH, MD, JOEL J	MONTOUR
BERBERICH, MD, WALTER F	WESTMORELAND
BERCELI, SCOTT A	STUDENT
BERDECIA, MD, MILA	ALLEGHENY
BERENBAUM, MD, PAUL L	PHILADELPHIA
BERENHOLZ, MD, LEONARD P	PHILADELPHIA
BERES, MD, JOSEPH C	PHILADELPHIA
BERESKY, MD, BARNABAS S	ERIE
BERESNY, MD, GERALD M	CENTRE
BEREZ, MD, FRANNE R	WESTMORELAND
BERG, MD, ALAN P	PHILADELPHIA
BERG, MD, BRUCE J	MONTGOMERY
BERG, MD, ERIC	YORK
BERG, MD, GEORGE	ALLEGHENY
BERG, MD, JAMES H	ALLEGHENY
BERG, MD, MORTON D	PHILADELPHIA
BERG, MD, PHILIP	PHILADELPHIA
BERG, MD, SAUL R	ALLEGHENY
BERGELSON, MD, VICTOR D	MONTGOMERY
BERGER, MD, ALAN	LEHIGH
BERGER, MD, ALAN S	PHILADELPHIA
BERGER, MD, BRIAN M	PHILADELPHIA
BERGER, MD, BRUCE C	PHILADELPHIA
BERGER, MD, GARY W	LYCOMING
BERGER, MD, GLEN W	PHILADELPHIA
BERGER, MD, JAY B	NORTHAMPTON
BERGER, MD, KARL	CAMBRIA
BERGER, MD, MALCOLM P	ALLEGHENY
BERGER, MD, MARC S	MONROE
BERGER, MD, MARK D	PHILADELPHIA
BERGER, RANDY	STUDENT
BERGER, MD, SIMON M	PHILADELPHIA
BERGER, MD, STANLEY R	PHILADELPHIA
BERGER, MD, WINFRIED M	HUNTINGDON
BERGHER, MD, MOISES	PHILADELPHIA
BERGMAN, MD, ELISABETH C	ALLEGHENY
BERGMAN, MD, GARY R	ALLEGHENY
BERGMAN, MD, MARTIN J	DELAWARE
BERGNES, MD, MANUEL A	MONTGOMERY
BERGQUIST, MD, ERICK J	WESTMORELAND
BERGSRUD, MD, RICHARD A	ALLEGHENY
BERING, MD, JOSEPH P	LEBANON
BERING, MD, THOMAS G	YORK
BERK, MD, DAVID A	ALLEGHENY
BERK, MD, H RONALD	ALLEGHENY
BERK, MD, HENRY M	MONTGOMERY

BERK, MD, MYLES M ALLEGHENY
BERK, MD, NATHANIEL G PHILADELPHIA
BERK, MD, ROBERT L BUCKS
BERK, MD, THEODORE F CUMBERLAND
BERKEBILE, MD, BRENDA L ALLEGHENY
BERKEBILE, MD, PAUL E ALLEGHENY
BERKEY, MD, KENT E ALLEGHENY
BERKEY, MD, RICHARD L ALLEGHENY
BERKHEIMER, MD, GEORGE A DAUPHIN
BERKHEISER, MD, SAMUEL W DAUPHIN
BERKMAN, MD, EUGENE F BEAVER
BERKMAN, MD, RONALD O ALLEGHENY
BERKOW, MD, DON A LANCASTER
BERKOW, MD, ROBERT MONTGOMERY
BERKOWITZ, MD, ALAN R LANCASTER
BERKOWITZ, MD, HENRY D PHILADELPHIA
BERKOWITZ, LORI R STUDENT
BERKOWITZ, MD, MORTON I ALLEGHENY
BERKOWITZ, MD, PETER J ALLEGHENY
BERKSON, DAVID A STUDENT
BERKWITS, MD, LELAND CHESTER
BERLEY, MD, BENJAMIN S LUZERNE
BERLIN, MD, ANDREW D ALLEGHENY
BERLIN, MD, CHARLES S ALLEGHENY
BERLIN, JONATHAN W STUDENT
BERLIN, MD, ROGER G MONTGOMERY
BERMAN, MD, ARNOLD T PHILADELPHIA
BERMAN, AUDREY B STUDENT
BERMAN, MD, ELI MONROE
BERMAN, MD, GAIL O MONTGOMERY
BERMAN, MD, HOWARD J WESTMORELAND
BERMAN, MD, IRA J YORK
BERMAN, MD, JEFFREY O ALLEGHENY
BERMAN, MD, MICHAEL A ALLEGHENY
BERMAN, MD, PETER D ALLEGHENY
BERMAN, ROBERT M STUDENT
BERNAL, MD, GUILLERMO J BUCKS
BERNARDINO JR, MD, VITALIANO B BUCKS
BERNATH JR, MD, ALBERT M MONTOUR
BERNE, MD, ELLEN S ALLEGHENY
BERNETT, MD, GARY B DELAWARE
BERNETT, MD, TIMOTHY M BRADFORD
BERNHARD, MD, ROBERT A LANCASTER
BERNIER, MD, GEORGE M ALLEGHENY
BERNS, MD, LEON L PHILADELPHIA
BERNSTEIN, MD, A ALEXANDER LACKAWANNA
BERNSTEIN, MD, BRAD PHILADELPHIA
BERNSTEIN, MD, GUY T MONTGOMERY
BERNSTEIN, DO, HENRY H BUCKS
BERNSTEIN, MD, LARRY PHILADELPHIA
BERNSTEIN, MD, MARK H BUCKS
BERNSTEIN, MD, ROBERT W ALLEGHENY
BERNSTINE, MD, EARL L YORK
BERNSTINE, MD, J BERNARD PHILADELPHIA
BERONILLA JR, MD, HILARION A FAYETTE
BERRY, MD, GEORGE J ALLEGHENY
BERSCHLING, MD, CHESTER M ALLEGHENY
BERTA, MD, JULIUS W WARREN
BERTGES, DANIEL J STUDENT
BERTOCCHI, MICHAEL E STUDENT
BERTOLETTE, MD, RICHARD D BERKS
BERTRAM, MD, HORST N LEBANON
BERTRAM, MD, KARL R TIOGA
BERTSCH, MD, ALBERT M SUSQUEHANNA
BERTSCH, MD, DAVID J CUMBERLAND
BERWICK, MD, EVELYN S ALLEGHENY
BESSELMAN, MD, DAVID M DAUPHIN
BEST, JOHN A STUDENT
BEST, MD, JOHN W YORK
BESWICK, MD, DAVID R LUZERNE
BETANCOURT, MD, SERGIO E ALLEGHENY
BETESH, MD, JOEL S DELAWARE
BETTINGER, MD, ROBERT ALLEGHENY
BETTS, DO, BROOKS NORTHAMPTON
BETTS, MD, CHARLES R ALLEGHENY
BETTS, MD, EUGENE K PHILADELPHIA
BETZ, MD, LOUIS H UNION
BETZ, MD, RANDAL R PHILADELPHIA
BEUTLER, MD, WILLIAM J DAUPHIN
BEVERLY, MD, AVERY W PHILADELPHIA
BEVERLY JR, MD, ROLAND S PHILADELPHIA
BEVILACQUA, MD, DANIEL F ADAMS
BEVILACQUA, MD, JOHN E PHILADELPHIA
BEVILACQUA, MD, LORRAINE B ALLEGHENY
BEYER, MD, DAVID W ALLEGHENY
BEYER, MD, H JEANNE CLEARFIELD
BEYER III, MD, FREDERICK C LANCASTER
BEYER JR, MD, FRANCIS D WESTMORELAND
BEYER JR, MD, KARL H PHILADELPHIA
BEZIER, MD, JEFFREY L ALLEGHENY
BHAGAT, MD, PRAGNA R MONROE
BHAGAT, MD, RAJESH G MONROE
BHAGWANANI, MD, DRUPADI G ALLEGHENY
BHAKTA, SANJAY C STUDENT
BHARUCHA, ASHOK J STUDENT
BHARUCHA, MD, SHERNAVAZ D DAUPHIN
BHASIN, MD, ARVIND BEAVER
BHAT, ELEANOR STUDENT
BHATIA, MD, SHYAMSUNDER MONTOUR
BHATNAGAR, MD, YUDHISHTER M CLARION
BHATT, MD, DRUPAD MONROE
BHATT, MD, NARESH I WASHINGTON
BHATT, MD, PRAFUL U CLINTON
BHAYANI, MD, SHABIR A MCKEAN
BHE, MD, H KWAN CARBON
BHUTANI, MD, VINOD K PHILADELPHIA
BHUTTA, MD, OMAR I ALLEGHENY
BHYUN, MD, DAE SOO YORK
BIAGAS, MD, KATHERINE V ALLEGHENY
BIAGINI, DO, TODD H ALLEGHENY
BIALAS, MD, HENRY N BERKS
BIALAS, MD, JEAN A CENTRE
BIALAS, MD, ROBERT F DELAWARE
BIAN, MD, YONG LING PHILADELPHIA
BIANCA III, MD, VINCENT C LACKAWANNA
BIANCARELLI, MD, SUSAN M LACKAWANNA
BIANROSA, MD, JOHN J PHILADELPHIA
BICKEL, MD, REBECCA L ALLEGHENY
BIDULA, MD, LEO P ALLEGHENY
BIDULA, MD, MAUREEN M ALLEGHENY
BIEBUYCK, MD, JULIEN F DAUPHIN
BIELE, MD, FLORA H PHILADELPHIA
BIEMULLER, MD, MARTHA L PHILADELPHIA
BIENIEK, MD, RUSSELL B ERIE
BIERBRAUER, MD, KARIN S PHILADELPHIA
BIERER, MD, EDWARD D ARMSTRONG
BIERI, MD, JOHN W DAUPHIN
BIERMAN, MD, EDWARD W PHILADELPHIA
BIERMANN, MD, WILLIAM A PHILADELPHIA
BIESER, DO, ROBERT D BLAIR
BIESINGER, MD, GEORGE J BLAIR
BIGGS, MD, LISA M PHILADELPHIA
BIGGS, DO, ROBERT H NORTHAMPTON
BIGLAN, MD, ALBERT W ALLEGHENY
BIGLER, MD, ROBERT D PHILADELPHIA
BIGOS, MD, EDWARD T BERKS
BIKLE, MD, CHARLES A FRANKLIN
BIKLE, MD, H DWIGHT ADAMS
BIKOWSKI, MD, JOSEPH B ALLEGHENY
BILBAO, MD, ANGEL ALLEGHENY
BILINSKI, MD, CAROL A ALLEGHENY
BILKER, MD, IRIS J PHILADELPHIA
BILL II, MICHAEL A STUDENT
BILLER, MD, AIMEE B ALLEGHENY
BILLIAR, MD, TIMOTHY R ALLEGHENY
BILLIG, MD, RUTH A PHILADELPHIA
BILLON, MD, ANDREW INDIANA
BILLY, GREGORY G STUDENT
BILSKY, MD, ALAN CHARLES PHILADELPHIA
BIMSON, MD, STEVEN S MONTGOMERY
BINAKONSKY, MD, HARRY S ALLEGHENY
BINDER, MD, ERIC J YORK
BINDER, MD, MICHAEL A VENANGO
BINDIE, MD, RICHARD P SCHUYLKILL
BINGHAM, MD, RODNEY S BLAIR
BINNICK, MD, STEVEN A MONTGOMERY
BINNS, MD, VERONICA FAYETTE
BINSTOCK, MD, HAROLD ALLEGHENY
BIRCHANSKY, MD, CHRISTINE A PHILADELPHIA
BIRCHER, MD, NICHOLAS G ALLEGHENY
BIRD, MD, LUIS J PHILADELPHIA
BIRD, MD, SHAWN J CHESTER
BIRK, MD, CATHERINE M ALLEGHENY
BIRMAHER, MD, BORIS ALLEGHENY
BIRNBAUM, MD, MICHAEL D PHILADELPHIA
BIRO JR, MD, FRANK NORTHAMPTON
BIRRELL, MD, DONALD G ALLEGHENY
BIRSIC, MD, WILLIAM I ALLEGHENY
BISACCO, MD, STEPHEN J BLAIR
BISCHOF, MD, RALPH O PHILADELPHIA
BISER, SETH A STUDENT
BISHAI, MD, DAVID M PHILADELPHIA
BISHOP, MD, DAVID W BLAIR
BISHOP, MD, JERRY W BERKS
BISHOP, MD, PONI S BRADFORD
BISHOP, MD, RICHARD L BRADFORD
BISHOP, MD, ROBERT P MONTGOMERY
BISHOP, MD, SARAH PHILADELPHIA
BISHOP, MD, WAYNE E CENTRE
BISHOW, MD, I RALPH PHILADELPHIA
BISIGNANI, MD, GABRIELLA M LACKAWANNA
BISKIN, MD, LAWRENCE C ALLEGHENY
BISORDI, MD, JOSEPH E MONTOUR
BISSET JR, MD, JAMES F NORTHAMPTON
BITAR III, H JOSEPH STUDENT
BITETTO, MD, NICOLA BERKS
BITMAN, MD, HAROLD L PHILADELPHIA
BITMAN, MD, JOSEPH PHILADELPHIA
BITNER, MD, WALTER P DAUPHIN
BITTENBENDER, SUSAN E STUDENT
BITTERLY, MD, THOMAS J MONTOUR
BITTINGER, MD, RALPH E YORK
BITTLER, MD, TAMMI L ALLEGHENY
BITTNER JR, EDWIN W STUDENT
BIUCKIANS, MD, EDWARD BUCKS
BIUSO, MD, THOMAS J LANCASTER
BIWOJNO, MD, CHRISTOPHER S ALLEGHENY
BIZOUSKY, MD, FRANKLIN S JEFFERSON
BIZUP, MD, THOMAS SCHUYLKILL
BJERKE, MD, JANET E WASHINGTON
BJORKLUND, MD, MARK D CUMBERLAND
BLACK, MD, JUDITH E ALLEGHENY
BLACK, MD, MARTIN PHILADELPHIA
BLACK, MD, MILTON H ALLEGHENY
BLACK, MD, PERRY PHILADELPHIA
BLACK, DO, SAMUEL J BUTLER
BLACK JR, MD, HARRY A ALLEGHENY
BLACK JR, MD, WILLIAM A LACKAWANNA
BLACKBURN, DO, JAMES H MONTOUR
BLACKBURN, MD, LAWRENCE F WESTMORELAND
BLACKBURN JR, MD, LAURENCE H BUCKS
BLACKLOW, MD, ROBERT S PHILADELPHIA
BLACKSMITH, DO, JAMES E DAUPHIN
BLACKSMITH, DO, WILLIAM A DAUPHIN
BLACKSMITH JR, MD, GARY L CUMBERLAND
BLAICHER, ELAINE H STUDENT
BLAIR, MD, ALBERT J ALLEGHENY
BLAIR, MD, FRANK W PHILADELPHIA
BLAISDELL, MD, C THEODORE LEHIGH
BLAISURE, MD, BEVERLY C CLEARFIELD
BLAKE, MD, DOUGLAS R LEHIGH
BLAKE, MD, HU A PHILADELPHIA
BLAKE, JIM J STUDENT
BLAKE, MD, KARL E ALLEGHENY
BLAKE, MD, PAUL O DELAWARE
BLAKELEY, DO, ANN K ALLEGHENY
BLAKELY, MD, KENT W MONTOUR
BLAKESLEE, DO, COLSON E JEFFERSON
BLAKLEY, MD, JOHN B ALLEGHENY
BLANCH, MD, JOSEPH J PHILADELPHIA
BLANCHARD, MD, MICHAEL D DAUPHIN
BLAND, MD, C BRINLEY PHILADELPHIA
BLANK, MD, IRA B MONTGOMERY
BLANK, MD, JOHN E PHILADELPHIA
BLANK, MD, SAMUEL PHILADELPHIA
BLANKENSHIP, MD, JAMES C MONTOUR
BLANNETT, MD, JOHN D DELAWARE
BLANZACO, MD, ANDRE C PHILADELPHIA
BLASIOL, DO, JOSEPH J LEHIGH
BLASS, MD, DAVID C FAYETTE
BLATCHLEY, MD, DONALD M WESTMORELAND
BLATT, MD, BRUCE I MONTGOMERY
BLATT, MD, MARK A PHILADELPHIA
BLAUM JR, MD, LOUIS C BRADFORD
BLAUM SR, MD, LOUIS C LUZERNE
BLAUSER, MD, ROBERT B BERKS
BLAZAR, MD, PHILIP E PHILADELPHIA
BLAZER, MD, DAVID J LEBANON
BLEACHER, MD, JOHN C DAUPHIN
BLECHER, MD, MARK H PHILADELPHIA
BLECKER, MD, DAVID YORK
BLEEDEN, MD, EDWARD M DELAWARE
BLEICHER, RICHARD J STUDENT
BLEICHNER, MD, JOHN C LYCOMING
BLEIMAN, MICHAEL I STUDENT
BLENDER, DO, BURTON PHILADELPHIA
BLEWETT, MD, CHARLES H POTTER
BLEWITT, MD, GEORGE A PHILADELPHIA
BLEZNAK, MD, AARON D CENTRE
BLIDNER, MD, MARTIN D LUZERNE
BLILEY, MD, KIRK S ALLEGHENY
BLINDER, MD, JEFFREY S LEHIGH
BLINKOFF, MD, BARRY A PHILADELPHIA
BLINN, MD, DAVID L ALLEGHENY
BLOCH, MD, ROBERT S NORTHAMPTON
BLOCK, MD, BRADLEY M LUZERNE
BLOCK, MD, GEOFFREY D ALLEGHENY
BLOCK, MD, GILBERT A PHILADELPHIA
BLOCK, MD, MARIAN R ALLEGHENY
BLOCK, MD, ROBERT A PHILADELPHIA
BLOCK, MD, ROBERT C CAMBRIA
BLOCK, MD, RONALD M DELAWARE
BLOCK, MD, STEVEN BUCKS
BLOCKSTEIN, MD, ROBERT S ALLEGHENY
BLODGETT JR, MD, RANDOLPH C MONTOUR
BLOES, MD, WALTER S LACKAWANNA
BLOISO, MD, GLENN T LYCOMING
BLOM, MD, BOHEN M F LYCOMING
BLOM, MD, JOHANNES LYCOMING
BLOMAIN, MD, E WILLIAM LACKAWANNA
BLOMAIN, MD, ERIC W LACKAWANNA
BLOMQUIST, MD, MATTHEW H PHILADELPHIA
BLONDEK, MD, STANLEY W LACKAWANNA
BLOOD JR, MD, JOSEPH B BRADFORD
BLOOM, MD, BENJAMIN H PHILADELPHIA
BLOOM, MD, FREDERICK J LUZERNE
BLOOM, GRETCHEN C STUDENT
BLOOM, HEIDI T STUDENT
BLOOM, MD, JOSEPH PHILADELPHIA
BLOOM, MD, LAWRENCE H PHILADELPHIA
BLOOM, MD, MARVIN A WESTMORELAND
BLOOM, MD, SANDRA L BUCKS
BLOOMER, MD, WILLIAM D ALLEGHENY
BLOOMGARDEN, MD, GAIL L STUDENT
BLOOMGARDEN, MD, RAPHAEL T PHILADELPHIA
BLOOMSTINE, MD, MARK T ERIE
BLORE JR, MD, JAMES P BUCKS
BLOSCHICHAK, MD, ANDREW SCHUYLKILL
BLOSE, MD, LINDA K NORTHAMPTON
BLOUGH, MD, LELAND S ALLEGHENY
BLUE, TODD M STUDENT
BLUEMLE JR, MD, LEWIS W PHILADELPHIA
BLUESTEIN, MD, DAVID D ALLEGHENY
BLUESTEIN, MD, HAZEL M MONTGOMERY
BLUESTONE, MD, CHARLES D ALLEGHENY
BLUM, MD, LARRY W PHILADELPHIA
BLUM, MD, RICHARD H LUZERNE
BLUMBERG, MD, ALEXANDER W LYCOMING
BLUMBERG, MD, BARUCH S PHILADELPHIA
BLUMBERG, MD, MYRON L PHILADELPHIA
BLUME, MD, ROBERT P ALLEGHENY
BLUMENFELD, MD, BARRY H ALLEGHENY
BLUMENFELD, MD, LOUIS C ALLEGHENY
BLUMENSCHEIN, MD, GERTRUDE FAYETTE
BLUMENTHAL, MD, ANDREW R MONTGOMERY
BLUMENTHAL, MD, SHERRY L PHILADELPHIA
BLUMSTEIN, MD, CHARLES G MONTGOMERY
BLUTSTEIN, MD, RICHARD N DAUPHIN
BLYDENBURGH, MD, SUSAN M CHESTER
BLYTH, MD, BRUCE PHILADELPHIA
BLYTHE, MD, PEGGY J WASHINGTON
BOAL, MD, ERWIN S BEAVER
BOAL, MD, RICHARD J DAUPHIN
BOAL JR, MD, JOHN H BEAVER
BOBAK, MD, WLADYSLAW FAYETTE
BOBBY, DO, JOHN L ALLEGHENY
BOBECK, MD, JOSEPH J LUZERNE
BOBEK, MD, FRANCIS B COLUMBIA
BOBICK, MD, FRANK CARBON
BOBIN, MD, JOHN J YORK
BOBRIN, BRAD D STUDENT
BOBRIN, DO, MARSHALL C PHILADELPHIA
BOCCAGNO, MD, PHILLIP A LACKAWANNA
BOCCIO, MD, REMIGIO V PHILADELPHIA
BOCHER, MD, JACK CHESTER
BODE JR, MD, FREDERICK W ALLEGHENY
BODEK, MD, ALVIN M ALLEGHENY
BODMER, MD, MERAL O NORTHMBRLAND
BODNER, MD, DARYL G LANCASTER
BODNER, MD, GAIL F LANCASTER
BOEHM, MD, MAUREEN C ALLEGHENY
BOEHM, ROSEMARIE STUDENT
BOEHME, MD, KEVIN G ALLEGHENY
BOEHNKE, MD, MANFRED ALLEGHENY
BOELLNER, MD, ALICIA A PHILADELPHIA
BOERIO, DO, MARGARET R DAUPHIN
BOGDANOFF, MD, BRUCE M DELAWARE
BOGDEWIC, MD, THOMAS A ALLEGHENY
BOGER, MD, WILLIAM P PHILADELPHIA
BOGERT, DO, ARTHUR EDWIN PHILADELPHIA
BOGERT, EUGENIA-PAULITA STUDENT
BOGUCKI, MD, EDWIN I DELAWARE
BOHATIUK, MD, GEORGE M ERIE
BOHEEN, ERICA A STUDENT
BOHINSKI, DO, STANLEY T LUZERNE
BOHLENDER, MD, GEORGE P ERIE
BOHM-VELEZ, MD, MARCELA ALLEGHENY
BOHNE, MD, MILDRED H T LEBANON
BOHNENBLUST, MD, WALTER R SCHUYLKILL
BOHNENBLUST JR, MD, WALTER R BERKS
BOHNER, MD, MARY F ALLEGHENY
BOHONYI, MD, WILLIAM A DAUPHIN
BOHRER, MD, MINDY S PHILADELPHIA
BOHRI, MD, JAMES D CARBON
BOHUN, THERESA R STUDENT
BOICE, MD, G NEWTON ALLEGHENY
BOK, MD, JOHN S CHESTER
BOLAND, MD, STANLEY W LACKAWANNA
BOLAND JR, MD, FRANCIS B BUCKS
BOLANDER, DO, CARRIE L LANCASTER
BOLANOVICH, MD, LESTER J ALLEGHENY
BOLANOWSKI, MD, DEBORAH J BUCKS
BOLDEN, MD, MARY C ALLEGHENY
BOLDEN, MD, PATRICK T PERRY
BOLDEN, MD, RICHARD O WESTMORELAND
BOLINGER, BEVERLY L STUDENT
BOLINGER, MD, MARK S HUNTINGDON
BOLLARD, EDWARD R STUDENT
BOLLIMPALLI, SRINIVAS S STUDENT
BOLLINGER, MD, JAMES R CHESTER
BOLMANN, MD, ANDREW R MONTGOMERY
BOLNO, DO, CHARLES M PHILADELPHIA
BOLOTIN, MD, JOSEPH H MERCER
BOLUS, MD, CHARLES M LACKAWANNA
BOMALASKI, MD, JOHN S CHESTER
BOMBARD JR, ROBERT A STUDENT
BONACORSI, MD, THOMAS F ALLEGHENY
BONACUM, DO, MICHAEL G MONTOUR
BONAGURA, MD, ANTHONY F PHILADELPHIA
BONAKDAR-POUR, MD, AKBAR PHILADELPHIA
BONANNI, MD, LORETTA D CHESTER
BONAROTI, MD, EUGENE A ALLEGHENY
BONAVENTURA, MD, MARGUERITE ALLEGHENY
BONCHEK, MD, LAWRENCE I LANCASTER
BOND, WILLIAM F STUDENT
BONDI, MD, EDWARD EDGE PHILADELPHIA
BONDI, MD, FRANK R ALLEGHENY
BONDI, MD, RICHARD P ALLEGHENY
BONDY, MD, THOMAS J CAMBRIA
BONE, LINDA J STUDENT
BONEKEMPER, MD, THOMAS W LEHIGH
BONESSI, MD, JAMES V ALLEGHENY
BONESSI, EXEC SEC, COBY WASHINGTON
BONFIGLIO, MD, RICHARD P CHESTER
BONGIOVANNI, DO, ANDREW G DELAWARE
BONI JR, MD, DINO R WASHINGTON
BONIFACE, MD, DOLORES J ALLEGHENY
BONITA, MD, LOUIS B LUZERNE
BONITA, MD, RAPHAEL LUZERNE
BONNEAU, MD, AMY J DAUPHIN
BONNER, MD, DENNIS J BUCKS
BONNER, MD, JAMES F PHILADELPHIA
BONNER, MD, JAMES J BERKS
BONNER, MD, MARY J BERKS
BONNER, MD, ROBERT E PHILADELPHIA
BONNER, MD, WILLIAM F BUCKS
BONNER JR, MD, FRANCIS J MONTGOMERY
BONO, MD, JOHN ARMSTRONG
BONONI, MD, PAULA A MONTGOMERY
BONOS III, MD, CHARLES T LEHIGH
BONTEMPO, MD, FRANKLIN A BEAVER
BONUCCI, MD, BRUNO L FAYETTE
BONWICH, JANINA B STUDENT
BOO, MD, KI T LEHIGH
BOOGAARD, MD, RONALD G LEBANON
BOOHER, MD, ERIN L ALLEGHENY
BOOK, MD, MORRIS M BEAVER
BOOKERT, MD, CHARLES C ALLEGHENY
BOONE, MD, EDGAR A MERCER
BOONE, MD, JOY L MERCER
BOONIN, MD, ALAN LUZERNE
BOONSWANG, MD, PRICHA NORTHAMPTON
BOONVISUDHI, MD, THUMRONG FAYETTE

BOOR, MD, JOHN W DELAWARE
BOORSE, MD, RICHARD C LEHIGH
BOORSTEIN, MD, JEFFREY M PHILADELPHIA
BOOTH, ALEXANDRA E STUDENT
BOOTH, MD, KEVIN R DELAWARE
BOOTH JR, MD, ROBERT E PHILADELPHIA
BOOVA, MD, ROBERT S DELAWARE
BORAH, MD, BISHNU C BUCKS
BORAN, MD, ROBERT P SCHUYLKILL
BORAN, MD, THOMAS V SCHUYLKILL
BORANS, STACY M STUDENT
BORCZON, MD, DENNIS P ERIE
BORDEN, MD, ANTHONY G PHILADELPHIA
BORDEN, DO, STANLEY J MONTGOMERY
BORECKY, MD, DAVID C CAMBRIA
BOREEN, MD, STUART M NORTHAMPTON
BORENSTEIN, MD, JULES PHILADELPHIA
BORETSKY, MD, HARRY ALLEGHENY
BORETSKY, MD, ROBERT H ALLEGHENY
BORGER, MD, LEE J WARREN
BORGIA, MD, FRANK A ALLEGHENY
BORGMAN, MD, JODY B PHILADELPHIA
BORJA, MD, ROGELIO I BUTLER
BORKOVIC, MD, EMBRIE J BEAVER
BORKOW, MD, JOEL E CAMBRIA
BORKOWSKI, MD, WINSLOW J PHILADELPHIA
BORLANDOE, MD, BEVERLY C PHILADELPHIA
BORN, MD, CHRISTOPHER T PHILADELPHIA
BORN, MD, MICHAEL W YORK
BORNS, MD, PATRICIA F PHILADELPHIA
BORNT, MD, MARSHA D YORK
BOROFSKY, MD, MICHAEL A BERKS
BORON, MD, ROBERT J CLEARFIELD
BORON, MD, RONALD L ALLEGHENY
BORON, MD, STELLA M INDIANA
BOROS, MD, TRACEY A STUDENT
BOROUMAND, MD, MASOOD CAMBRIA
BOROW, MD, LAWRENCE S PHILADELPHIA
BOROW, MD, SYDNEY PHILADELPHIA
BOROWSKI, MD, GREGORY D LACKAWANNA
BORRA, MD, BOLLIAH LUZERNE
BORROR, MD, MEGAN J DAUPHIN
BORSETT-KANTER, MD, LESLIE M ALLEGHENY
BORTIN, MD, LEONARD PHILADELPHIA
BORTNER, MD, DONALD L YORK
BORTS, MD, FREDERICK T NORTHAMPTON
BORTZ, MD, DONALD W WESTMORELAND
BORUS, MD, HARRY E ALLEGHENY
BORYS, DAVID J STUDENT
BORZUTZKY, MD, CARLOS A ALLEGHENY
BOSACCO, MD, STEPHEN J PHILADELPHIA
BOSAK, MICHAEL D STUDENT
BOSCHA, MD, KENNETH W WESTMORELAND
BOSCHI, MD, ALESSANDRO S CARBON
BOSCIA, MD, JEROME A PHILADELPHIA
BOSCO, MD, CARIN R ALLEGHENY
BOSELLI, MD, BRUCE D BRADFORD
BOSSARD, MD, VALERIE J PHILADELPHIA
BOSSART, MD, BARBARA A ERIE
BOSSE, MD, MILTON D ALLEGHENY
BOSSIO, ADRIENNE E STUDENT
BOTEK, MD, ALISON A STUDENT
BOTKIN, MD, LESTER H ALLEGHENY
BOTOMAN, MD, V ALIN ALLEGHENY
BOTROS, MD, MAUREEN R STUDENT
BOTTGER, MD, DAVID A DELAWARE
BOTTONI, THOMAS N STUDENT
BOUCHER, MD, WILLIAM F LEHIGH
BOUDER, MD, THOMAS G BRADFORD
BOUR, MD, ERIC S DAUPHIN
BOURDAKOS, MD, DEMETRIOS BLAIR
BOUREKAS, MD, ERIC C ALLEGHENY
BOUVIER, MD, MARIANNE ALLEGHENY
BOVE, MD, FRANK A PHILADELPHIA
BOVE, MD, RICHARD L PHILADELPHIA
BOWEN, MD, A'DELBERT ALLEGHENY
BOWEN, MD, ANNE C CHESTER
BOWEN, MD, DALE T LEHIGH
BOWEN, FRANK W STUDENT
BOWEN, MD, ROBERT E BRADFORD
BOWEN JR, MD, FRANK W PHILADELPHIA
BOWEN JR, MD, THALES MONTGOMERY
BOWER, MD, HARRY B DAUPHIN
BOWER, MD, JAMES H DAUPHIN
BOWER, MD, JAMES N LAWRENCE
BOWER, MD, JOHN R BERKS
BOWER, MD, ROBERT PHILADELPHIA
BOWER SR, MD, JOHN R BERKS
BOWERS, MD, BARBARA A YORK
BOWERS, MD, DAVID W LANCASTER
BOWERS, MD, LEROY W BLAIR
BOWERS, MD, PAUL A PHILADELPHIA
BOWERS, MD, RICHARD A ALLEGHENY
BOWES, MD, DONALD E MONTOUR
BOWIE, MD, MORRIS A MONTGOMERY
BOWMAN, MD, DAVID H BLAIR
BOWMAN, GLEN F STUDENT
BOWMAN, MD, HERBERT S DAUPHIN
BOWMAN, MD, JAMES E PHILADELPHIA
BOWMAN, MD, JOHN H LANCASTER
BOWMAN, MD, MICHAEL W ALLEGHENY
BOWMAN, MD, ROBERT G WESTMORELAND
BOWMAN JR, MD, DOUGLAS F MCKEAN
BOWMAN JR, MD, THOMAS E DAUPHIN
BOXER, MD, ARTHUR D MONTGOMERY
BOXER, MD, LOUIS M PHILADELPHIA
BOYADJIS, MD, TERRENCE A PHILADELPHIA
BOYD, MD, KENNETH J DELAWARE
BOYD, MD, ROBERT L DELAWARE
BOYD, MD, WILLIAM J DAUPHIN
BOYD III, MD, THOMPSON H PHILADELPHIA
BOYD-KRANIS, MD, ROBIN L PHILADELPHIA
BOYEK, MD, MICHAEL F BRADFORD
BOYER, MD, GEORGE S LEHIGH
BOYER, DO, MICHAEL A BERKS
BOYER, MD, RANDAL A PHILADELPHIA
BOYER, MD, WALTER E VENANGO
BOYER JR, MD, JOSEPH H LEHIGH
BOYKIW, MD, MARK E INDIANA
BOYKIW, MD, RUSSEL A CLEARFIELD
BOYLAN, MD, JAMES J NORTHAMPTON
BOYLAN JR, MD, RAYMOND J ALLEGHENY
BOYLE, MD, BRIAN F WESTMORELAND
BOYLE, MD, DENIS A DELAWARE
BOYLE, MD, EILEEN M ALLEGHENY
BOYLE, MD, GRACE K LUZERNE
BOYLE, MD, HUGH G LUZERNE
BOYLE, MD, JAMES W ALLEGHENY
BOYLE, MD, L EAMONN YORK
BOYLE, MARY C STUDENT
BOYLE, MD, RONALD N CAMBRIA
BOYLE, MD, WILLIAM H LUZERNE
BOYLE JR, MD, DENIS A DELAWARE
BOYLER, MD, LAWRENCE J FRANKLIN
BOYLSTON, MD, BEDFORD F DAUPHIN
BOYSEN, MD, HOMER SCHUYLKILL
BOZIC, MD, ALBERT F LYCOMING
BOZORGZADEH, MD, ADEL ALLEGHENY
BRABAZON, DO, JOHN F LANCASTER
BRABENDER, MD, REBECCA R ALLEGHENY
BRABSON, MD, HOWARD W BEAVER
BRACCIA, DO, DOMENICK PHILADELPHIA
BRACCIA, MD, GREGORY M PHILADELPHIA
BRACE, MD, FREDERICK H PHILADELPHIA
BRACKBILL, MD, ELIZABETH J BERKS
BRACKIN, MD, GEORGE G BUCKS
BRACKIN, MD, PHILLIP S MONTGOMERY
BRACKUP, MD, ALAN B MONTGOMERY
BRADBURD, DO, TRINA L DELAWARE
BRADEN, MD, GEOFFREY L PHILADELPHIA
BRADEN JR, MD, FRANK R ALLEGHENY
BRADFIELD, HAROLD A STUDENT
BRADFORD, MD, BRADLEY J ALLEGHENY
BRADFORD, MD, JOHN D CHESTER
BRADFORD, MD, PAUL L MONTGOMERY
BRADFORD, DO, WILLIAM C LANCASTER
BRADLEY, DO, BETTY H ALLEGHENY
BRADLEY, ELIZABETH A STUDENT
BRADLEY, MD, JAMES P PHILADELPHIA
BRADLEY, MD, JAMES P ALLEGHENY
BRADLEY, MD, ROBERT M ALLEGHENY
BRADLEY, MD, SAMUEL M CAMBRIA
BRADLEY, MD, VERNON F BLAIR
BRADLEY, MD, WILLIAM L WESTMORELAND
BRADLEY JR, MD, ROBERT H PHILADELPHIA
BRADLEY JR, MD, WILLIAM P ALLEGHENY
BRADSTREET, MD, R PERRY DAUPHIN
BRADY, MD, DOUGLAS F WESTMORELAND
BRADY, MD, JAMES P MONTGOMERY
BRADY, MD, JOSEPH J PHILADELPHIA
BRADY, MD, LUTHER W PHILADELPHIA
BRAFFMAN, MD, MICHAEL N PHILADELPHIA
BRAGDON, MD, ROBERT W ALLEGHENY
BRAHMAKULAM, MD, PAUL M MIFFLIN/JUNI
BRAHOS, MD, ANTHONY G CLEARFIELD
BRAITMAN, MD, ROBERT A PHILADELPHIA
BRALLIER, MD, HUGH W WESTMORELAND
BRALOW, MD, S PHILIP PHILADELPHIA
BRAMOWITZ, MD, ALAN D ALLEGHENY
BRANAS, DO, JOHN A LANCASTER
BRANCATO, MD, JOHN C PHILADELPHIA
BRAND, MD, ASHER ALLEGHENY
BRAND, MD, CAROL E ALLEGHENY
BRANDFASS, MD, W TAYLOR DELAWARE
BRANDMAN, MD, ITA S PHILADELPHIA
BRANDON, MD, JOHN M WASHINGTON
BRANDON, MD, MILTON B JEFFERSON
BRANDSTETTER, MD, LOUIS H ALLEGHENY
BRANDT, MD, DOUGLAS M MERCER
BRANDT, MD, JOHN P CLINTON
BRANDT, MD, ROBERT I BEAVER
BRANDT, RODNEY D STUDENT
BRANDY, MD, DOMINIC A ALLEGHENY
BRANICK, JOANNA R STUDENT
BRANIN, DO, BRUCE K LACKAWANNA
BRANNAC, MD, PATRICK G FRANKLIN
BRANON, DO, CHERYL A DELAWARE
BRANSCUM, MD, GEORGE P CUMBERLAND
BRANT, MD, CARL E WESTMORELAND
BRANTNER, MD, JIM N MERCER
BRASILE, DO, DOMENICK J ERIE
BRASLOW, MD, NORMAN H DELAWARE
BRAUN, MD, DENNIS R MONTGOMERY
BRAUN, MD, JEAN B FAYETTE
BRAUN, DO, KURT W MONTGOMERY
BRAUN, MD, MARIA A BERKS
BRAUN, MD, SARAH J PHILADELPHIA
BRAUN, STEPHANIE M STUDENT
BRAUN III, MD, WILLIAM P NORTHAMPTON
BRAUNEGG JR, MD, PAUL W LYCOMING
BRAUNFELD, DO, ROBERT DELAWARE
BRAUNSTEIN, LARRY STUDENT
BRAUTIGAM, ROBERT T STUDENT
BRAV, MD, SOLOMON S PHILADELPHIA
BRAVEMAN, MD, BERNARD L ALLEGHENY
BRAVETTE, MD, BARRY A PHILADELPHIA
BRAY, MD, CARYN L ERIE
BRAY, MD, JOHN P BLAIR
BRAY, MD, JOHN S DAUPHIN
BRAY, MD, JOSEPH B CHESTER
BRAY, MD, JOSHUA C MONTGOMERY
BRAY, MD, SUSAN H PHILADELPHIA
BRAZEL, MD, JOSEPH F CUMBERLAND
BREAKSTONE, MD, LOUISE A LUZERNE
BREARLY, MD, WAYNE R CHESTER
BRECHER, MD, EUGENE PHILADELPHIA
BRECHER, MD, JEFFREY A BUCKS
BRECKENRIDGE, AMY C STUDENT
BRECKENRIDGE, MD, JOHN W MONTGOMERY
BREE, DO, STANTON A CHESTER
BREECKER, MD, STEVEN W PHILADELPHIA
BREHM, MD, HANS H MONROE
BREIN, MD, KENNETH R YORK
BREINING, DWAYNE A STUDENT
BREIT, MD, ROBERT N ALLEGHENY
BREITE, MD, HERBERT J BRADFORD
BREITFELD, MD, VOLKER ALLEGHENY
BREMER, MD, HARRY J CAMBRIA
BREN, DO, DEBORAH A LEHIGH
BRENEMAN, MD, JOHN W FRANKLIN
BRENES, MD, GILBERT ALLEGHENY
BRENKER, MD, HOWARD J DAUPHIN
BRENMAN, MD, ARNOLD K PHILADELPHIA
BRENMAN, MD, SCOTT A PHILADELPHIA
BRENN, MD, PAULA D WESTMORELAND
BRENNAN, DO, EDWARD C DAUPHIN
BRENNAN, MD, JAMES T PHILADELPHIA
BRENNAN, MD, JOSEPH E PHILADELPHIA
BRENNAN, MD, RICHARD E BEAVER
BRENNAN, MD, ROBERT W DAUPHIN
BRENNEMAN, MD, PAUL G BUCKS
BRENNEMAN, MD, RICHARD E NORTHAMPTON
BRENNEN, MD, ROBERT F LEHIGH
BRENNER, MD, BARRY S PHILADELPHIA
BRENNER, MD, LOUIS O DAUPHIN
BRENNER, DO, RICHARD P PHILADELPHIA
BRENNER-WILLIAMS, MD, CARYN M DAUPHIN
BRENT, MD, BRADLEY H ALLEGHENY
BRENT, GEOFFREY J STUDENT
BRENT, MD, LAWRENCE B ALLEGHENY
BRENT, MD, NANCY B ALLEGHENY
BRERETON, MD, HARMAR D LACKAWANNA
BRERETON, MD, WILLIAM F ERIE
BRESLIN, MD, JANET M ALLEGHENY
BRESLIN, MD, JOSEPH A LANCASTER
BRESLIN, MD, KENNETH S BUCKS
BRESS, MD, ALAN N ALLEGHENY
BRESS, MD, JAMES C ALLEGHENY
BRESSLER, MD, WILLIAM L HUNTINGDON
BREST, MD, ALBERT N PHILADELPHIA
BREST, MD, NORMAN A MONTGOMERY
BRESTICKER, MD, DAVID H LYCOMING
BRETHAUER JR, MD, EDWARD A ALLEGHENY
BRETT III, MD, GEORGE W BEAVER
BRETTZKE, MD, CECIL B LUZERNE
BRETZ, MD, KAREN A LEHIGH
BREUNINGER, DO, HOLLY G PHILADELPHIA
BREVETTA, MD, RICHARD J MERCER
BRIAN, CHRISTOPHER M STUDENT
BRIAN, JAMES M STUDENT
BRICKER, MD, SAMUEL Q FRANKLIN
BRICKHOUSE, MD, HERMAN M LYCOMING
BRICKLEY, MD, KENNETH S CLINTON
BRICKLEY, MD, RICHARD S WESTMORELAND
BRICKNELL, MD, PAUL P DAUPHIN
BRIDE, DO, THOMAS P YORK
BRIDENBAUGH, MD, G ALAN YORK
BRIDENBAUGH, MD, ROBERT P BLAIR
BRIDGENS, DO, NANCY K CHESTER
BRIER, MD, PETER M DAUPHIN
BRIGHAM, MD, MARK P CHESTER
BRIGHAM, MD, ROBERT A BERKS
BRIGHTON, MD, CARL T PHILADELPHIA
BRIGNOLA, MD, MICHAEL P PHILADELPHIA
BRILL, MD, DAVID R MONTOUR
BRILL, MD, FRANCIS W LACKAWANNA
BRILL, MD, JOSEPH M DELAWARE
BRILL, KRISTIN L STUDENT
BRILL, MD, LESSA A UNION
BRILL, MD, PAUL A ALLEGHENY
BRILLMAN, MD, DAVID A ALLEGHENY
BRILLMAN, MD, JON ALLEGHENY
BRINDISI, MD, GAETANO PHILADELPHIA
BRINKMEYER, DO, SCOTT D ALLEGHENY
BRINZ, MD, LAURA A JEFFERSON
BRISINI, MD, PATRICK D CAMBRIA
BRISKIN, MD, JONATHAN A DELAWARE
BRISLIN, DO, MARIE T NORTHMBRLAND
BRISLIN, DO, ROBERT P MONTOUR
BRISTOWE, KEVIN D STUDENT
BRITTON, ERIC L STUDENT
BRITTON, MD, L LYNNE DAUPHIN
BRIZUELA, MD, HERNAN R PHILADELPHIA
BROAD, MD, LOUIS T PHILADELPHIA
BROCK, MD, CHARLENE M PHILADELPHIA
BROCK, MD, RICHARD R DAUPHIN
BROCKMAN, MD, RONALD J MONTGOMERY
BROCKMAN, MD, STANLEY K PHILADELPHIA
BROCKMEYER, MD, THOMAS F ALLEGHENY
BROCKMOLE, MD, DEAN M DAUPHIN
BROCKMYER, MD, M LAWRENCE ERIE
BROD, MD, JENNIFER S DELAWARE
BROD, MD, ROBERT C DELAWARE
BROD, MD, ROY D LANCASTER
BRODER, MD, GEORGE J PHILADELPHIA
BRODER, JONATHAN D STUDENT
BRODIE, MD, DONALD E BUCKS
BRODIE, MD, WALTER E MCKEAN
BRODKIN, MD, JOSHUA S PHILADELPHIA
BRODMERKEL JR, MD, GEORGE J ALLEGHENY
BRODOVSKY, MD, HARVEY S PHILADELPHIA
BRODSKY, MD, ISADORE PHILADELPHIA
BRODSKY, MD, JEFFREY T PHILADELPHIA
BRODSKY, MD, ROBERT L ALLEGHENY
BRODSKY, MD, STEVEN G BEAVER
BRODY, MD, JEROME I PHILADELPHIA
BRODY, MD, JULIA B PHILADELPHIA
BRODY, MD, LEONARD A PHILADELPHIA
BRODY, MD, MARION B PHILADELPHIA
BRODY, MD, MICHAEL C BEAVER
BRODY, MD, MORRIS W PHILADELPHIA
BROENNLE, MD, A MICHAEL PHILADELPHIA
BROGAN, MD, EDMUND J PHILADELPHIA
BROGAN, MD, LOUIS E PHILADELPHIA
BROMAN, MD, JENNIFER J ALLEGHENY
BROMBERG, MD, JONATHAN PHILADELPHIA
BROMMER, MD, OLIVER R PHILADELPHIA
BRON, MD, KLAUS M ALLEGHENY
BRONFMAN, MD, HOWARD J DAUPHIN
BRONITSKY, MD, BARBARA G YORK
BRONITSKY, MD, CARL N DAUPHIN
BRONNER, MD, MARGARET A PHILADELPHIA
BRONSTEIN, MD, HOWARD D PHILADELPHIA
BRONSTEIN, MD, ROBERT M PHILADELPHIA
BRONSTEIN, MD, SEYMOUR B LUZERNE
BROOKER, MD, DAVID ROBERT PHILADELPHIA
BROOKS, BRIAN P STUDENT
BROOKS, MD, DANIEL H ALLEGHENY
BROOKS, DO, FRANK J WASHINGTON
BROOKS, MD, GERALD M CRAWFORD
BROOKS, MD, HARRY R DAUPHIN
BROOKS, MD, JACK C LAWRENCE
BROOKS, MD, JAMES L GREENE
BROOKS, MD, JANE F WAYNE/PIKE
BROOKS, DO, JOHN M CLARION
BROOKS, MD, MICHAEL J MONTGOMERY
BROOKS, MD, MICHAEL L PHILADELPHIA
BROOKS, MD, ROBERT PHILADELPHIA
BROOKS, MD, RONALD J MONTGOMERY
BROOKS, SUSAN L STUDENT
BROOKS, DO, TIMOTHY S CLARION
BROOKS III, MD, JAMES L ALLEGHENY
BROOKS JR, MD, CLINT E DELAWARE
BROPHY, MD, DOW E CUMBERLAND
BROSBE, MD, DONNA L LANCASTER
BROSCIUS, MD, BENJAMIN M NORTHMBRLAND
BROSELOW, MD, DAVID D PHILADELPHIA
BROSNAN, MD, WILLIAM J PHILADELPHIA
BROSS, MD, JAMES E MONTOUR
BROSS, RONALD J STUDENT
BROSTOFF, MD, LEON M ALLEGHENY
BROSTOFF, MD, PHILIP ALLEGHENY
BROTHERS, BONNIE L STUDENT
BROUDO, MD, SAMUEL F PHILADELPHIA
BROUDY, MD, ARNOLD S ALLEGHENY
BROUGHER, MD, DAVID E ALLEGHENY
BROUSSARD, MD, ELSIE R ALLEGHENY
BROUSSEAU, DAVID A STUDENT
BROWN, MD, A CRAIG ERIE
BROWN, MD, ANDREW J ALLEGHENY
BROWN, DO, AVROM S PHILADELPHIA
BROWN, MD, CHARLES R ALLEGHENY
BROWN, MD, CHRISTOPHER L LEHIGH
BROWN, MD, CLARK E PHILADELPHIA
BROWN, MD, DANIEL J BRADFORD
BROWN, MD, DENNIS P WASHINGTON
BROWN, MD, DONALD C WESTMORELAND
BROWN, MD, ELIZABETH B DELAWARE
BROWN, MD, FREDERICK G MONTOUR
BROWN, MD, GARY C PHILADELPHIA
BROWN, MD, GEORGE L MONTGOMERY
BROWN, MD, GREGORY P MONTGOMERY
BROWN, MD, GREGORY P FRANKLIN
BROWN, MD, H ZANE LANCASTER
BROWN, MD, HAROLD E MONTOUR
BROWN, DO, HAROLD M PHILADELPHIA
BROWN, MD, J OLIVER PHILADELPHIA
BROWN, MD, JOEL D ALLEGHENY
BROWN, MD, JOHN H MERCER
BROWN, MD, JOHN L CLINTON
BROWN, MD, JOHN M NORTHAMPTON
BROWN, MD, JOY M MONROE
BROWN, MD, KENNETH R PHILADELPHIA
BROWN, MD, LESLIE A PHILADELPHIA
BROWN, MD, LINDA E PHILADELPHIA
BROWN, M CHRISTINE STUDENT
BROWN, MD, MANSON VENANGO
BROWN, MD, MANUEL L ALLEGHENY
BROWN, DO, MARION L DELAWARE
BROWN, MD, MARK S POTTER
BROWN, MD, MATTHEW G MERCER
BROWN, MD, MELANIE C PHILADELPHIA
BROWN, MD, MELISSA M PHILADELPHIA
BROWN, MD, MICHAEL D UNION
BROWN, MD, NATHAN CHESTER
BROWN, MD, NORDELL T MONTOUR
BROWN, MD, PATTI J BERKS
BROWN, MD, RALPH R INDIANA
BROWN, MD, RAYMOND D PHILADELPHIA
BROWN, MD, RICHARD J LANCASTER
BROWN, MD, ROBERT B ALLEGHENY
BROWN, MD, ROBERT E LANCASTER
BROWN, MD, ROBERT L LUZERNE
BROWN, MD, SCOTT D SOMERSET
BROWN, MD, SYLVAN LACKAWANNA
BROWN, MD, THOMAS E MONTOUR
BROWN, MD, VICTORIA A LEBANON
BROWN, MD, WILLIAM E MERCER
BROWN, MD, WILLIAM E MONTGOMERY
BROWN, MD, WYNNE R E ALLEGHENY
BROWN JR, MD, JAMES T ALLEGHENY
BROWN JR, MD, JOSEPH S MIFFLIN/JUNI
BROWN JR, MD, LOUIS A PHILADELPHIA
BROWN JR, MD, M EVANS MONTGOMERY

BROWN JR, MD, WILLIAM C	BUCKS
BROWN V, MD, THOMAS W	BUCKS
BROWN-BIEBER, MD, DALE E	LEBANON
BROWNSTEIN, MD, BRUCE K	PHILADELPHIA
BROWNSTEIN, MD, PHILLIP K	PHILADELPHIA
BRUBAKER, MD, J KENNETH	LANCASTER
BRUBAKER, MD, JACOB H	LANCASTER
BRUBAKER, MD, PAUL E	LANCASTER
BRUBAKER, MD, WARREN W	DAUPHIN
BRUCE, MD, WILLIAM B	UNION
BRUCKER, MD, ALEXANDER J	PHILADELPHIA
BRUCKER, MD, PAUL C	PHILADELPHIA
BRUDER, JOHN B	STUDENT
BRUEBCHKE, ERICH R	STUDENT
BRUNDAGE, DO, RANDALL G	LACKAWANNA
BRUNGO, MD, JAMES J	ALLEGHENY
BRUNGO, MD, JOHN A	ALLEGHENY
BRUNGO, MD, JOHN D	ALLEGHENY
BRUNNER, MD, DOUGLAS J	DELAWARE
BRUNNER, MD, RICHARD A	PHILADELPHIA
BRUNO, MD, JORGE C	ALLEGHENY
BRUNO, MD, LEONARD A	PHILADELPHIA
BRUNO, LISA M	STUDENT
BRUNO, MD, PAT J	NORTHUMBERLAND
BRUNO, MD, STEPHEN C	ALLEGHENY
BRUNO JR, MD, JOSEPH N	LUZERNE
BRUNO SR, MD, JOSEPH N	LUZERNE
BRUNSKILL, MD, DENNIS E	ALLEGHENY
BRUNT JR, MD, MANLY Y	PHILADELPHIA
BRUTICO, MD, ANTHONY C	LACKAWANNA
BRUTICO JR, MD, CARMEN A	LACKAWANNA
BRYAN, MD, FRANK B	CUMBERLAND
BRYAN, MD, THOMAS M	DAUPHIN
BRYAN JR, MD, JOHN B	BUCKS
BRYAN JR, MD, ROSS E	WARREN
BRYANSMITH, MD, DALE	PHILADELPHIA
BRYANT, DAVID B	STUDENT
BRYANT, MD, DAVID W	CUMBERLAND
BRYANT JR, MD, WINSTON M	PHILADELPHIA
BRYLAWSKI, MD, MICHAEL	PHILADELPHIA
BRYS, MD, DAVID A	ALLEGHENY
BRYSON, MD, RICHARD L	LANCASTER
BRZANA, MD, RONALD J	ALLEGHENY
BRZEZINSKI, MD, SANDRA A	CAMBRIA
BRZOZOWSKI, MD, JAN F	ERIE
BRZOZOWSKI, MD, LAWRENCE A	BERKS
BRZOZOWSKI, MD, LEONARD L	PHILADELPHIA
BSAT, MD, FADI A	ALLEGHENY
BU, MD, TAE-HYUNG	ERIE
BUB, MD, IVAN	BERKS
BUBENHEIM, MD, DANIEL M	ALLEGHENY
BUCAN, MD, MICHAEL	LUZERNE
BUCAR, MD, JOHN R	ALLEGHENY
BUCCI, MD, ARTHUR J	ALLEGHENY
BUCCI, MD, LORENZO A	WESTMORELAND
BUCCO, DO, MARIA C	DELAWARE
BUCH, MD, DAVID L	MONTGOMERY
BUCH, MD, ROBERT R	LANCASTER
BUCH, MD, SANDHYA Y	BERKS
BUCHANAN IV, MD, HARRY W	LEHIGH
BUCHDAHL, MD, ALICE J	ALLEGHENY
BUCHER, MD, ROBERT G	BUCKS
BUCHER JR, MD, ROBERT W	DAUPHIN
BUCHHEIT, MD, WILLIAM A	PHILADELPHIA
BUCHMAN, MD, ROBERT R	ALLEGHENY
BUCHSBAUM, MD, ROY	ALLEGHENY
BUCK, MD, ANN L	ALLEGHENY
BUCK, MD, DAVID B	ALLEGHENY
BUCK, MD, DONALD E	PHILADELPHIA
BUCK, MD, KEITH K	ARMSTRONG
BUCK, MD, RUDOLPH L	ALLEGHENY
BUCK, MD, RUTH E	MONTGOMERY
BUCKEY, MD, JOSEPH T	LUZERNE
BUCKINGHAM, MD, ROBERT B	ALLEGHENY
BUCKINGHAM, MD, ROBERT C	DAUPHIN
BUCKLEN, MD, KEITH R	LANCASTER
BUCKLER, MD, RICHARD A	BUCKS
BUCKLEW, MD, LAWRENCE A	ALLEGHENY
BUCKLEY, MD, MARINA	WAYNE/PIKE
BUCKLEY, MD, RICHARD E	WAYNE/PIKE
BUCKLEY, MD, ROLAND M	PHILADELPHIA
BUCKMAN, MD, SAMUEL T	LUZERNE
BUCKO JR, MD, MATTHEW I	MONTGOMERY
BUCKTHAL, MD, PAUL E	BRADFORD
BUCKWALTER, MD, JEFFREY A	BUCKS
BUCKWALTER, MD, RICHARD A	MONTGOMERY
BUCKWALTER, MD, VICTOR L	LANCASTER
BUCS, MD, ROGER G	DAUPHIN
BUDD, CATHERINE B	STUDENT
BUDD, MD, ROBERT M	BLAIR
BUDEIR, MD, MOHAMMED H	CHESTER
BUDENZ, MD, DONALD L	DELAWARE
BUDURA, MD, PAUL	NORTHAMPTON
BUECHEL, MD, PAUL C	BRADFORD
BUENDIA, MD, ANTONIO V B	NORTHUMBERLAND
BUENO, MD, JOSEPHA	ALLEGHENY
BUERGER, MD, DAVID G	ALLEGHENY
BUERGER JR, MD, GEORGE F	ALLEGHENY
BUERK, MD, MINERVA B	MONTGOMERY
BUETOW, MD, MICHAEL P	DAUPHIN
BUFFONE, MD, DAVID A	JEFFERSON
BUHL, MD, KEITH J	PHILADELPHIA
BUHR, MD, BRUCE R	DAUPHIN
BUI, LEHIEN T	STUDENT
BUINEWICZ, MD, BRIAN R	MONTGOMERY
BULATAO, MD, AGAPITO V	BERKS
BULGARELLI, DO, ROBERT J	DELAWARE
BULGER, MD, DONALD W	BLAIR
BULGER, MD, RICHARD H	BLAIR
BULKLEY, MD, ANDREW D	BUCKS
BULLARD JR, MD, RAY E	WESTMORELAND
BULLOCK, MD, BRIAN W	DELAWARE
BULLUCK, MD, DAVID E	PHILADELPHIA
BULOVA, MD, STEPHEN I	PHILADELPHIA
BULSECO, MD, PATRICIA J	ALLEGHENY
BUMBY, DO, NOREEN A	LYCOMING
BUMGARDNER, MD, JAMES L	BUCKS
BUNAO, MD, ROMULO M	BRADFORD
BUNDY, MD, THOMAS W	FRANKLIN
BUNESE, MD, HORST J	PHILADELPHIA
BUNKER, MD, MARK L	ALLEGHENY
BUNYA, MD, VATHANA O	PHILADELPHIA
BUNYA, MD, VICHAI	PHILADELPHIA
BUNYOR, MD, AGNES K	HUNTINGDON
BUONOCORE, MD, BONNITA K	MONTGOMERY
BURAK, MD, WILLIAM E	LUZERNE
BURD, MD, MARK D	MONTOUR
BURDEN, MD, SAMUEL B	MONTGOMERY
BURDICK, MD, MITCHELL	ERIE
BURDZIAK, DO, DOROTHY A	PHILADELPHIA
BURES, MD, J CONRAD	WESTMORELAND
BURG, MD, FREDRIC D	PHILADELPHIA
BURGBACHER, MD, JAMES B	CAMBRIA
BURGER, MD, JOSEPH G	BEAVER
BURGER, MD, REGIS F	ALLEGHENY
BURGER, MD, THEODORE P	NORTHAMPTON
BURGESS, MD, DONALD R	ALLEGHENY
BURGESS, MD, GEOFFREY M	CHESTER
BURGET JR, MD, DEAN E	CHESTER
BURGEY, MD, GAIL E	NORTHAMPTON
BURGIN, MD, WALTER H	DAUPHIN
BURGO, MD, ALFRED J	ALLEGHENY
BURICK, MD, SHEILA M	MONTOUR
BURK, MD, CHERYL D	YORK
BURKE, GERRIANNE	STUDENT
BURKE, MD, GREG F	PHILADELPHIA
BURKE, MD, JAMES M	PHILADELPHIA
BURKE, MD, JEROME M	BUCKS
BURKE, MD, KEVIN W	CENTRE
BURKE, MD, M SUSAN	MONTGOMERY
BURKE, MD, MARSHALL L	BEAVER
BURKE, MD, MARY D	MONTGOMERY
BURKE, MD, ROBERT E	CLEARFIELD
BURKE III, MD, CHARLES J	ALLEGHENY
BURKE III, MD, FRANCIS X	DELAWARE
BURKET, MD, LOUIS C	BLAIR
BURKET, MD, RAMON C	BLAIR
BURKETT, MD, DONALD E	CAMBRIA
BURKEY, MD, DAVID J	ALLEGHENY
BURKEY, MD, FRED J	ALLEGHENY
BURKHOLDER, MD, JOHN A	ALLEGHENY
BURKLE, MD, JOSEPH B	YORK
BURKLEY JR, MD, LOUIS F	NORTHAMPTON
BURKS, MD, JOHN M	LYCOMING
BURLAND, MD, J ALEXIS	PHILADELPHIA
BURLINGAME, MD, JANET M	ALLEGHENY
BURLINGAME, MD, MARK W	LANCASTER
BURMAN, MD, KERSTIN M	ALLEGHENY
BURMEISTER, MD, CHARLES W	BUCKS
BURNETT, DO, CARL D	MONTGOMERY
BURNEY, MD, LEROY E	MONTGOMERY
BURNO, DERRICK K	STUDENT
BURNS, BARBARA J	STUDENT
BURNS, CYNTHIA A	STUDENT
BURNS, MD, DONALD T	BERKS
BURNS, DO, ELIZABETH A	PHILADELPHIA
BURNS, MD, FRANK D	FRANKLIN
BURNS, MD, J ROBERT	MONTOUR
BURNS, MD, RICHARD K	MONTGOMERY
BURNS, MD, WILLIAM T	DAUPHIN
BURNS JR, MD, CHARLES N	LUZERNE
BURNS SR, MD, CHARLES N	LUZERNE
BURNSIDE, MD, JOYCE A	MONTOUR
BURR, MD, RANDALL D	MONTOUR
BURROUGHS, MD, BETH A	STUDENT
BURROWS, CHARLES B	STUDENT
BURROWS, MD, STANLEY B	PHILADELPHIA
BURRY, MD, WILLIAM C	MONROE
BURSALI, MD, SALAHATTIN	WESTMORELAND
BURSTEIN, MD, FRANK	PHILADELPHIA
BURSTEIN, MD, STUART S	ALLEGHENY
BURSTEIN, MD, WILLIAM H	PHILADELPHIA
BURTON, DO, PAUL D	INDIANA
BUSCH, MD, MICHAEL F	LEHIGH
BUSCHI, MD, MARIE	DAUPHIN
BUSECK, MD, MARK B	ERIE
BUSH, MD, BRUCE A	INDIANA
BUSH, DANA M	STUDENT
BUSH, MD, DAVID C	MONTOUR
BUSH, MD, HERMAN	BEAVER
BUSH, MD, JAMES W	LEBANON
BUSH, MD, STEPHEN T	CAMBRIA
BUSH, MD, TODD A	DELAWARE
BUSHKOFF, MD, STANLEY H	ALLEGHENY
BUSHLESS, MD, DIANA L	ALLEGHENY
BUSHMAN, MD, KARL E	ALLEGHENY
BUSHWICK, MD, BRUCE M	YORK
BUSILLO, MD, NICHOLAS A	DELAWARE
BUSIS, MD, NEIL A	ALLEGHENY
BUSIS, MD, SIDNEY N	ALLEGHENY
BUSLER JR, MD, VERNE M	YORK
BUTCHER, MD, RICHARD J	MONTOUR
BUTCHKO, MD, ANDREW W	MERCER
BUTELA, SHAWN R	STUDENT
BUTERA, MD, VINCENT	YORK
BUTERBAUGH, MD, GLENN A	ALLEGHENY
BUTERBAUGH, MD, JOHN E	LYCOMING
BUTKIEWICZ, MD, BERNARD L	LYCOMING
BUTLER, MD, ANNE K	TIOGA
BUTLER, MD, CHARLES H	CHESTER
BUTLER, MD, IVAN L	YORK
BUTLER, JOHN E	STUDENT
BUTLER, MD, MELVIN V	PHILADELPHIA
BUTSON, MD, HARRY E	PHILADELPHIA
BUTT, MD, HAMEED A	LUZERNE
BUTT JR, MD, FRANK H	WARREN
BUTTER, DEBIREE B	STUDENT
BUTTERFIELD, MD, SPENCER L	ALLEGHENY
BUTTERWORTH, MD, THOMAS	BERKS
BUXTON JR, MD, DONALD R	DAUPHIN
BUYERS, MD, ROBERT A	MONTGOMERY
BUZAD, FRANCIS A	STUDENT
BUZAS, MD, JEROME W	BERKS
BUZBY, MD, FRANKLIN B	PHILADELPHIA
BUZBY, MD, GORDON P	PHILADELPHIA
BUZZELLI, MD, PHILIP B	ALLEGHENY
BYBEL, MD, ANN M	LANCASTER
BYBEL, MD, GRETCHEN	ERIE
BYBEL, MD, NICHOLAS	BERKS
BYER, MD, HAROLD H	BUCKS
BYERS, MD, JAMES F	ALLEGHENY
BYERS, MD, JOHN A	ALLEGHENY
BYERS, MD, KARIN E	PHILADELPHIA
BYERS, MD, ROBERT O	ERIE
BYLER, MD, ARTHUR B	CHESTER
BYLER, MD, PHILIP R	LYCOMING
BYRNE, BOBBI J	STUDENT
BYRNE, MD, EARL B	MONTGOMERY
BYRNE, MD, JAMES E	NORTHAMPTON
BYRNE, MD, KEVIN J	PHILADELPHIA
BYRNE, MD, WILLIAM E	DAUPHIN
BYRNES, WILLIAM J	STUDENT
BYRON, MD, HAROLD J	MONTGOMERY
BYRON, MD, THOMAS W	LUZERNE
BYUN, MD, STANLEY Y	NORTHUMBERLAND
BYUN, MD, SUNG T	ALLEGHENY

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CABALLE, MD, JOSE B	ALLEGHENY
CABRERA, MD, RAFAEL	WASHINGTON
CABRY JR, MD, ROBERT J	DELAWARE
CACCESE JR, MD, RAPHAEL	PHILADELPHIA
CACCHIONE, DO, PHILIP M	ERIE
CACCHIONE, ROBERT N	STUDENT
CACCIAMANI, JOHN D	STUDENT
CADMAN, MD, THOMAS E	MONTOUR
CADY, MD, HERBERT M	PHILADELPHIA
CADY, MD, JOSEPH B	BRADFORD
CADY, MD, WILLIAM W	BRADFORD
CAGGIANO, MD, JAMES F	LUZERNE
CAGGIANO, MD, JOHN D	CHESTER
CAHAN, MD, MICHAEL B	PHILADELPHIA
CAHAN, MD, ROBERT B	PHILADELPHIA
CAHILL, MD, DAVID J	BEAVER
CAHILL, MD, DAVID M	TIOGA
CAHILL, MD, THOMAS J	MONTOUR
CAHN, MD, MILTON M	PHILADELPHIA
CAIN, ERIC L	STUDENT
CAIN, DO, JACQUELINE F	LUZERNE
CAIN, MD, JAMES G	STUDENT
CAINE, MD, MARK E	ALLEGHENY
CAIRGLE, RODERICK G	STUDENT
CAIRNS, MD, LUCY J	BERKS
CALABRESE, DO, CHARLES R	FAYETTE
CALABRESE, MD, JAMIE	ALLEGHENY
CALABRETTA, MD, ARTHUR M	YORK
CALABRO, MD, SAL P	PHILADELPHIA
CALANDRA, MD, GARY B	PHILADELPHIA
CALATA, MD, ELISEO R	BERKS
CALBOT-SCZEPANSKI, MD, CYNTHIA L	MONTGOMERY
CALCAGNO, MD, DAVID	DAUPHIN
CALCE, MD, JOHN V	LYCOMING
CALDER JR, MD, JOSEPH R	LYCOMING
CALDERON, MD, AMADOR G	UNION
CALDWELL, J MICHAEL	STUDENT
CALDWELL, MD, MATTHEW W	ALLEGHENY
CALEB, MD, MAE H	DELAWARE
CALES, MD, ROBERT J	PHILADELPHIA
CALESNICK, MD, BENJAMIN	PHILADELPHIA
CALETRI, MD, DAVID K	MONTGOMERY
CALHOUN, MD, JOSEPH H	PHILADELPHIA
CALI, DO, GREGORY E	LACKAWANNA
CALIENDO, MARK V	STUDENT
CALIGUIRI, MD, JOSEPH V	ALLEGHENY
CALIGUIRI, MD, LAWRENCE A	ALLEGHENY
CALISE, MD, CRESCENZO G	LUZERNE
CALISTO, MARIETTA K	STUDENT
CALKINS, MD, JOSEPH L	LANCASTER
CALLAGAHAN, MD, DANIEL A	LUZERNE
CALLAGHAN, MD, DANIEL J	LAWRENCE
CALLAGHAN, MD, MARIAN P	PHILADELPHIA
CALLAHAN, MD, MARY F	CENTRE
CALLAHAN, DO, MICHAEL E	POTTER
CALLCOTT-STEVENS, MD, VICTOR A	FRANKLIN
CALLENBERGER, MD, GEORGE J	LYCOMING
CALLENBERGER, MD, RONALD W	TIOGA
CALLERY, MD, GERALD E	PHILADELPHIA
CALLEY, MD, WILLIAM D	CLEARFIELD
CALLIGARO, MD, KEITH D	PHILADELPHIA
CALLIS, MD, STEWART J	GREENE
CALVANEBE, MD, NICHOLAS A	ALLEGHENY
CAMA, MD, JOSEPH	BRADFORD
CAMBEST JR, MD, MICHAEL A	ALLEGHENY
CAMBIER, MD, DAVID W	ALLEGHENY
CAMELE, MD, ROBERT A	FAYETTE
CAMERON, MD, DONALD D	LUZERNE
CAMERON, MD, DONALD Y	ALLEGHENY
CAMITTA, MD, FRANCINE D	YORK
CAMMARANO III, DO, DOMINIC J	BERKS
CAMMARATA, MD, ROY J	ALLEGHENY
CAMODY-JOHNSTON, MD, PATRICIA A	PHILADELPHIA
CAMP, MD, ANTHONY M	MONTGOMERY
CAMP, MD, MARK O	DELAWARE
CAMPAGNA, MD, JAMES T	ALLEGHENY
CAMPAGNARI, MD, CHRISTOPHER A	BEAVER
CAMPANA, MD, FREDERICK T	WESTMORELAND
CAMPANA, MD, JOSEPH F	LYCOMING
CAMPANA, MD, LOUIS F	LYCOMING
CAMPANELLA, MD, PETER C	STUDENT
CAMPANELLA, MD, STEPHEN D	ALLEGHENY
CAMPBELL, MD, BARBARA J	SOMERSET
CAMPBELL, MD, CHARLES E M	BUCKS
CAMPBELL, CONNIE J	STUDENT
CAMPBELL, MD, DAVID B	DAUPHIN
CAMPBELL, MD, DAVID R	COLUMBIA
CAMPBELL, MD, ERNEST W	COLUMBIA
CAMPBELL, MD, JENNIFER H	ALLEGHENY
CAMPBELL, MD, JOHN T	PHILADELPHIA
CAMPBELL, MD, JOSEPH D	ALLEGHENY
CAMPBELL, MD, JOSEPH J	CUMBERLAND
CAMPBELL, MD, NAVNEET S	CUMBERLAND
CAMPBELL, MD, NEIL P	BUCKS
CAMPBELL, MD, ROBERT E	PHILADELPHIA
CAMPBELL, MD, ROBERT J	COLUMBIA
CAMPBELL, MD, SEAN C	YORK
CAMPBELL, MD, STEPHEN E	DAUPHIN
CAMPBELL, DO, THOMAS M	LUZERNE
CAMPBELL, MD, TIMOTHY M	ALLEGHENY
CAMPBELL, MD, WILLIAM J	DAUPHIN
CAMPBELL JR, MD, JAMES M	CENTRE
CAMPISI, DANIELLE J	STUDENT
CAMPO, DO, TARCISIO B	NORTHAMPTON
CAMPONOVO, MD, ERNEST J	DAUPHIN
CAMPSEY, D MICHAEL	STUDENT
CANALS, MD, JOAQUIN	MONTGOMERY
CANCELMO, MD, RICHARD P	MONTGOMERY
CANDAL, MD, MARIO A	LEHIGH
CANDELARIA, MD, JOSEFINA M	ALLEGHENY
CANDELL, MD, ELIZABETH J	PHILADELPHIA
CANDER, MD, LEON	PHILADELPHIA
CANDIA, MD, ANDREA J	BUCKS
CANE, MD, MARTIN	PHILADELPHIA
CANINO, MD, CHRISTOPHER W	PHILADELPHIA
CANLAS, MD, JOLLY B	NORTHAMPTON
CANN III, MD, THOMAS W	YORK
CANNER, MD, GARY C	BERKS
CANNON, MD, CHRISTOPHER S	LEBANON
CANNON, MD, EDWARD J	PHILADELPHIA
CANNON, MD, GARY T	SOMERSET
CANNONE, MD, DOMINICK	ALLEGHENY
CANO, MD, ELMER R	ALLEGHENY
CANOSE, MD, JEFFREY L	ALLEGHENY
CANTERNA, MD, ANTHONY C	WASHINGTON
CANUSO, MD, NICHOLAS A	PHILADELPHIA
CAPLAN, MD, AARON	LAWRENCE
CAPLAN, MD, BERNARD	PHILADELPHIA
CAPLAN, MD, HOWARD B	PHILADELPHIA
CAPLAN, MD, JOHN L	PHILADELPHIA
CAPLAN, MD, MILTON L	LAWRENCE
CAPLAN, MD, MURRAY B	PHILADELPHIA
CAPLAN, MD, PAUL B	ALLEGHENY
CAPOBIANCO, MD, FRANK M	NORTHAMPTON
CAPOBRES JR, MD, RUDOLFO M	WASHINGTON
CAPONE, MD, GAETANO J	PHILADELPHIA
CAPONE, MD, RALPH A	WESTMORELAND
CAPONE JR, MD, RAYMOND A	ALLEGHENY
CAPPA, MD, ROBERT J	BERKS
CAPPIELLO, MD, JUSTIN L	LANCASTER
CAPPIELLO, MD, WILLIAM A	BUCKS
CAPPOLA JR, MD, MICHAEL T	PHILADELPHIA
CAPPUCCIO, MD, MATTHEW S	PHILADELPHIA
CAPUTO, MD, CYNTHIA J	PHILADELPHIA
CAPUTO, MD, LARRY A	PHILADELPHIA
CAPUZZI, MD, DAVID M	PHILADELPHIA
CARABALLO, RICARDO	STUDENT
CARABASI, MD, R ANTHONY III	PHILADELPHIA
CARABASI, MD, RALPH A	PHILADELPHIA
CARABELLI, MD, RONALD J	PHILADELPHIA
CARABELLO, MD, CHARLES A	BERKS
CARACAPPA, DO, PAUL M	BERKS
CARAMANNA, MD, JAMES F	WESTMORELAND
CARANDANG-PANIS, MD, NORMA H	PHILADELPHIA
CARAPELLA, MD, JOHN D	LEHIGH
CARAZOLA, MD, JOSEPH H	WASHINGTON
CARBAUGH, MD, HOWARD L	LEHIGH
CARBO, DO, ANTHONY P	DELAWARE
CARBONELL, MD, JUAN ARTURO A	CAMBRIA
CARBONI, MD, VINCENT A	LUZERNE
CARDAMONE, MD, RALPH A	ALLEGHENY
CARDAMONE, MD, S JOSEPH	PHILADELPHIA
CARDELLINO, MD, THOMAS J	CAMBRIA
CARDENAS, MD, FLORENCIO P	FAYETTE
CARDINALE, DO, JOSEPH P	DAUPHIN
CARDLIN, MD, KENNETH M	DAUPHIN
CARDONE, MD, ANITA L	ALLEGHENY
CARDONE, MD, RICHARD A	NORTHAMPTON
CAREL, MD, WARREN D	PHILADELPHIA
CARELLA, MD, RICHARD J	MONTGOMERY
CARETTI, MD, J WILLIAM	WESTMORELAND
CAREY, MD, EDWARD J	LUZERNE
CAREY, MD, EVA B	ALLEGHENY
CAREY, MD, JOHN L	LUZERNE
CAREY, MD, JOHN T	BEAVER
CAREY, MD, KEVIN V	BRADFORD
CAREY, MD, PHILIP D	CUMBERLAND
CARHART, MD, JUDY A	DAUPHIN

CARIM, MD, HYDER M	BERKS
CARIM, MD, MOIZ M	BERKS
CARINI, MD, JOHN F	LANCASTER
CARINO, MD, MARIEL G	LACKAWANNA
CARL, MD, DAVID A	LUZERNE
CARL, MD, GARY H	ALLEGHENY
CARLETON, MD, MARTA J	MONTOUR
CARLIN, MD, ELWIN S	MONTGOMERY
CARLIN, MD, GERALD J	ALLEGHENY
CARLIN, MD, HUGH M	NORTHAMPTON
CARLIN, MD, MARIE C	BUCKS
CARLINI, MD, CHARLES J	ALLEGHENY
CARLOS, MD, HECTOR J	BUCKS
CARLOW, MD, JOSEPH F	CHESTER
CARLSON, MD, JOHN E	BERKS
CARLSON, MD, JOHN P	MONTOUR
CARLSON, MD, KENNETH E	BEAVER
CARLSON, MD, ROBERT E	MONTGOMERY
CARLSON, MD, STEPHEN E	BERKS
CARLSSON, MD, CHRISTER	PHILADELPHIA
CARLUCCI, MD, RONALD J	PHILADELPHIA
CARMEN, MD, THOMAS F	ALLEGHENY
CARMONA, MD, ALDO	MONROE
CARNABUCI, MD, GUY J	PHILADELPHIA,
CARNAVIL, DO, BRIAN D	MONTGOMERY
CARNEVAL, DO, DANIEL C	ERIE
CARNEVALE, MD, THOMAS A	CLEARFIELD
CARNEVALI, WILLIAM S	STUDENT
CARNEY, MD, DAVID J	MONTOUR
CARNEY, MD, FRANK T	CAMBRIA
CARNEY, MD, PAUL L	CENTRE
CARNEY, MD, SHARON K	PHILADELPHIA
CAROE, MD, ALAN E	YORK
CAROFF, MD, ROMUALD J	CAMBRIA
CARP, MD, ALBERT A	PHILADELPHIA
CARP, MD, LEON M	PHILADELPHIA
CARP, MD, MASON J	DAUPHIN
CARPANZANO, MD, CARMELA R	ALLEGHENY
CARPENTER, MD, CATHY P	YORK
CARPENTER, MD, JEFFREY P	PHILADELPHIA
CARPENTER, MD, LINDA N	ALLEGHENY
CARPINIELLO, MD, VICTOR L	PHILADELPHIA
CARPOUSIS, MD, AVRA H	PHILADELPHIA
CARR, MD, JAMES V	ALLEGHENY
CARR, MD, WILLIAM F	DAUPHIN
CARRATO, MD, ANTHONY M	DELAWARE
CARRELL, MD, ROBERT L	ALLEGHENY
CARRICK, JOHN S	STUDENT
CARRIER, MD, JUDITH M	CAMBRIA
CARRIER, MD, WILLIAM W	CAMBRIA
CARROLL, DO, EDMUND T	BUCKS
CARROLL, MD, JOAN B	PHILADELPHIA
CARROLL, MD, LAURENCE E	LANCASTER
CARROLL, MD, NANCY E	ALLEGHENY
CARROLL, MD, ROBERT J	ALLEGHENY
CARROLL, MD, ROBERT T	PHILADELPHIA
CARROLL, MD, STANTON F	PHILADELPHIA
CARROLL, MD, WILLIAM L	DELAWARE
CARROZZA, MD, HARRY D	PHILADELPHIA
CARRUTHERS, MD, RALPH B	LANCASTER
CARSON, MD, CHARLES P	DELAWARE
CARSON, MD, DONALD G	ALLEGHENY
CARSON, MD, GREGORY B	PHILADELPHIA
CARSON, MD, JAMES H	LANCASTER
CARSON, MD, JOHN S	MONTGOMERY
CARSON, MICHAEL P	STUDENT
CARSON, MD, TERESA C	MONTGOMERY
CARSON, MD, THOMAS E	WARREN
CARSON III, MD, JOHN N	YORK
CARTAGINESE, MD, PETER	BRADFORD
CARTAYA, DANIEL I	STUDENT
CARTER, MD, DANIEL J	ALLEGHENY
CARTER, DONALD J	STUDENT
CARTER, MD, DONALD L	WESTMORELAND
CARTER, MD, HOWARD A	CAMBRIA
CARTER, MD, JEFFREY E	PHILADELPHIA
CARTER, MD, JOHN A	BEAVER
CARTER, MD, JOSEPH H	ERIE
CARTER, MD, RICARDO T D D	MIFFLIN/JUNI
CARTER, MD, THOMAS L	HUNTINGDON
CARTER JR, MD, JOSEPH H	YORK
CARTER-DIVEN, MD, JUDITH	ALLEGHENY
CARTWRIGHT, MD, RICHARD L	CAMBRIA
CARTWRIGHT, MD, SCOTT R	DAUPHIN
CARTY JR, MD, JAMES B	MONTGOMERY
CARUANA, MD, BRUCE J	BERKS
CARUGATI, MD, RICHARD K	BEAVER
CARUSO, MD, JOHN W	PHILADELPHIA
CARUSO, JUNE M	STUDENT
CARUSO, DO, THOMAS D	MONTGOMERY
CARVAJAL, MD, ROBERTO T	BUCKS
CARVELLI, MD, JOSEPH A	ERIE
CARVER, MD, JOSEPH R	PHILADELPHIA
CARVER, MD, MARGARET A	FAYETTE
CARY, MD, GENE L	DAUPHIN
CASAL, MD, ROLANDO A	DAUPHIN
CASALE, MD, LAWRENCE F	CAMBRIA
CASALE, MD, LOUIS J	BUCKS
CASALE, MD, PETER J	MONROE
CASALE, DO, TONI SAN MARIA	CUMBERLAND
CASASNOVAS, MD, STELLA	PHILADELPHIA
CASCIOTTI, DO, MICHAEL S	DAUPHIN
CASDORPH, MICHAEL L	STUDENT
CASE JR, MD, WARREN G	PHILADELPHIA
CASELLA, MD, SALVATORE R	MONTGOMERY
CASELLO, MD, JEAN M	ALLEGHENY
CASERTA, MD, VITO M	MIFFLIN/JUNI
CASEY, MD, JOHN D	MONROE
CASEY, MD, KEVIN	PHILADELPHIA
CASEY, MD, MICHAEL P	ALLEGHENY
CASEY, MD, THOMAS J	MONTGOMERY
CASEY-MANCANO, MD, MARYANN P	BERKS
CASH, MD, JOSEPH M	ALLEGHENY
CASH, MD, STEPHEN L	PHILADELPHIA
CASPER, MD, DANIEL R	WESTMORELAND
CASS, MD, PAUL T	DELAWARE
CASSEL, MD, FRANKLIN K	LANCASTER
CASSEL, MD, JOHN J	LEHIGH
CASSELBERRY, MD, E JOSEPHINE	NORTHAMPTON
CASSELBRANT, MD, MARGARETHA L	ALLEGHENY
CASSELLI, MD, HELENE J	PHILADELPHIA
CASSIDY, ELLEN B	STUDENT
CASSIDY, MD, HARVEY D	MONTOUR
CASSIDY, MD, JOSEPH A	BLAIR
CASSIDY, MD, WILLIAM J	PHILADELPHIA
CASSOFF, MD, RICHARD G	ALLEGHENY
CASSONE, MD, GARY J	LACKAWANNA
CASTAGNA, MD, ARMAND	PHILADELPHIA
CASTALDO, MD, WILLIAM A	LEHIGH
CASTELLANO, MD, THOMAS J	LUZERNE
CASTELLI, MD, DARIO D	ALLEGHENY
CASTELLI II, MD, PETER J	SOMERSET
CASTELLI JR, DO, JOSEPH L	MONTGOMERY
CASTELLON, MD, LOURDES	CAMBRIA
CASTELLON-VOGEL, MD, CARLOS H	CAMBRIA
CASTIGLIONE, MD, ANGELO	ALLEGHENY
CASTILLO, MD, JOSE	PHILADELPHIA
CASTILLO, MD, MANUEL M	ALLEGHENY
CASTILLO, MD, RAUL C	PHILADELPHIA
CASTILLO, MD, WILLIAM M	ALLEGHENY
CASTLE, MD, CHARLES A	LANCASTER
CASTLE, MD, WILLIAM N	ALLEGHENY
CASTO, DANIEL	STUDENT
CASTOR, MD, LOUIS H	PHILADELPHIA
CASTOR, STANLEY A	STUDENT
CASTRINA JR, MD, FRANK P	CUMBERLAND
CASTRO, MD, ARTURO F	ALLEGHENY
CASTRO, MD, AUGUSTO D	ALLEGHENY
CASTRO, MD, OTHONIEL	ERIE
CASTROVINCI, MD, ROBERT V	PHILADELPHIA
CASWELL, MD, HORACE T	PHILADELPHIA
CATALANE, MD, DAVID B	ALLEGHENY
CATALANO, MD, ANTHONY C	NORTHUMBERLAND
CATALANO, MD, JOHN B	PHILADELPHIA
CATALANO, MD, KATHLEEN F	WESTMORELAND
CATALANO JR, MD, LOUIS W	WESTMORELAND
CATANIA, ROBERT A	STUDENT
CATENA, MD, ELIZABETH P	ALLEGHENY
CATENA, MD, MICHAEL R	ALLEGHENY
CATENA JR, MD, WILLIAM P	ALLEGHENY
CATTANO, MD, CHARLES J	ALLEGHENY
CATTON, MD, RAYMOND M	CHESTER
CAUCCI, DO, EMILIO J	PHILADELPHIA
CAUFFMAN, MD, WILLIAM J	BUCKS
CAUTILLI, MD, DAVID A	PHILADELPHIA
CAUTILLI, MD, GEORGE P	MONTGOMERY
CAUTILLI, MD, RICHARD A	MONTGOMERY
CAUTILLI JR, MD, RICHARD A	PHILADELPHIA
CAVAN, MD, ALBINA B	LUZERNE
CAVAN, MD, JOHN F	LUZERNE
CAVANAUGH, MD, MICHAEL F	MONTGOMERY
CAVASINA, MD, MARY M	WASHINGTON
CAVORSI, MD, JOSEPH P	BERKS
CAVOTO, MD, FRANCIS V	MONTGOMERY
CAVOTO, MD, MICHAEL J	INDIANA
CAVUTO, DO, CAROLYN M	PHILADELPHIA
CAWOG, MD, ANTOINE F	WESTMORELAND
CECH, MD, ROSANNE	LACKAWANNA
CEDERSTROM, MD, JANICE J	PHILADELPHIA
CEDRONE, MD, FRANCINE ANNE	PHILADELPHIA
CEFARATTI, MD, MICHAEL D	BERKS
CELANI, MD, VICTOR J	LEHIGH
CELEBRE, MD, JOAN A	MONTGOMERY
CELIN, MD, SCOTT E	ALLEGHENY
CELIO, MD, LEE A	PHILADELPHIA
CELKO, MD, DAVID A	ALLEGHENY
CELLINI, MD, L LUKE	DELAWARE
CENEDELLA, MD, STEPHEN C	VENANGO
CENTENO, MD, LIGAYA V M	PHILADELPHIA
CENTENO, ROBERT F	STUDENT
CERA JR, MD, PETER J	MONTOUR
CERCIELLO, MD, MARK J	LEHIGH
CERCONE, DO, DAVID J	ALLEGHENY
CERCONE, MD, RONALD G	ALLEGHENY
CERIMELE, MD, NICHOLAS A	CAMBRIA
CERMAK, MD, MARY BETH	ERIE
CERNADAS, MANUELA	STUDENT
CERNE, MD, ANDREW J	WESTMORELAND
CERRA, SONJA L	STUDENT
CERRI, MD, HUGO J M	ALLEGHENY
CERTA, MD, KENNETH M	PHILADELPHIA
CERTO, MD, LOUIS M	ALLEGHENY
CERTO, MD, SALVATORE A	ALLEGHENY
CERUL, MD, MAURICE S	ALLEGHENY
CESANEK, MD, JOSEPH E	LUZERNE
CESARE, MD, JOSEPH G	LACKAWANNA
CESTELLO, MD, ROBERT J	ALLEGHENY
CEVALLOS, MD, EDUARDO A	BUCKS
CHABRA, MD, MOHAN L	ALLEGHENY
CHABY, DO, JEFFREY H	LANCASTER
CHACKO, MD, JOSEPH G	MONTGOMERY
CHADAGA, MD, P C S	DELAWARE
CHADDAH, MD, ASHOK	INDIANA
CHADWICK, MD, HAROLD H	BRADFORD
CHAFFEE, MD, JOHN S	ERIE
CHAHIN, MD, JUAN J	ALLEGHENY
CHAI, MD, CHIU L	BUCKS
CHAI, MD, MARK D	YORK
CHAI, MD, MIN S	LACKAWANNA
CHAIT, MD, ARNOLD	PHILADELPHIA
CHAITOFF, MD, KEVIN A	BLAIR
CHALAL, MD, GERALD S	PHILADELPHIA
CHALAL, MD, KENNETH	PHILADELPHIA
CHALFANT, MD, JOHN C	FAYETTE
CHALFANT, MD, RICHARD S	ALLEGHENY
CHALFIN, MD, RICHARD F	DELAWARE
CHALFIN, ROBERT J	STUDENT
CHALLENER, MD, KENNETH R	CRAWFORD
CHALLINOR, MD, SUE M	ALLEGHENY
CHAMBERS, MD, CHRISTOPHER V	PHILADELPHIA
CHAMBERS, JENNIFER A	STUDENT
CHAMBERS, MD, MARTIN L	JEFFERSON
CHAMOVITZ, MD, BRUCE N	BEAVER
CHAMOVITZ, MD, JEROME	ALLEGHENY
CHAMOVITZ, MD, ROBERT	ALLEGHENY
CHAN, MD, ANNE K	PHILADELPHIA
CHAN, MD, DANIEL M	FRANKLIN
CHAN, MD, IAN	NORTHAMPTON
CHAN, MD, JANE W	PHILADELPHIA
CHAN, MD, KENNY H	ALLEGHENY
CHAN, PAUL C	STUDENT
CHANDRA, MD, DINESH N	ALLEGHENY
CHANDRA, MD, PRASANTA C	PHILADELPHIA
CHANDRA, MD, RAMESH R	ALLEGHENY
CHANDRA, MD, BEETHALAHEMI	ALLEGHENY
CHANDRA-MOHAN, MD, AVVERAHALLIM	LUZERNE
CHANDRAN, MD, GIRIJA	CAMBRIA
CHANDRASEKARAN, MD, RAMAMURTI	ALLEGHENY
CHANDRASEKARAN, MD, BANNABE	WESTMORELAND
CHANG, MD, AILEEN D	ALLEGHENY
CHANG, MD, ALEXANDER C S	ALLEGHENY
CHANG, MD, BENJAMIN	PHILADELPHIA
CHANG, MD, CHARLES H	WESTMORELAND
CHANG, MD, CHE-YI	NORTHAMPTON
CHANG, MD, CHRIS C	DAUPHIN
CHANG, MD, CHUN S	LUZERNE
CHANG, MD, CLAYTON W	MONTGOMERY
CHANG, MD, DUCK-KYU	CUMBERLAND
CHANG, MD, EDWARD J	ALLEGHENY
CHANG, MD, IN-HO	LEHIGH
CHANG, MD, KUN T	PHILADELPHIA
CHANG, MD, MONA P	LYCOMING
CHANG, RICHARD S	STUDENT
CHANG, SHIRLEY S	STUDENT
CHANG, MD, TONY CHI-KUE	NORTHAMPTON
CHANG, WON S	STUDENT
CHANG-LIPSENTHAL, MD, KATHY H	PHILADELPHIA
CHANGCO, MD, ALVARO N	WASHINGTON
CHANNAPATI, MD, THIPPESWAMY	BUTLER
CHANNICK, MD, BERTRAM J	PHILADELPHIA
CHANNICK, MD, STEVEN A	MONTGOMERY
CHAO, MD, WEN	PHILADELPHIA
CHAPA, MD, SUKUMAR M	CLARION
CHAPIS, MD, GREGORY J	PHILADELPHIA
CHAPIS, MD, NICHOLAS J	MONTGOMERY
CHAPLAN, MD, SANDRA R	ALLEGHENY
CHAPLER, MD, SUSAN P	ALLEGHENY
CHAPLIN, MD, STANLEY S	PHILADELPHIA
CHAPMAN, MD, ALBERT L	DAUPHIN
CHAPMAN, DO, ANDREW E	PHILADELPHIA
CHAPMAN, MD, CHRISTOPHER N	NORTHAMPTON
CHAPMAN, MD, JOSEPH L	PHILADELPHIA
CHAPMAN, MD, WILLIAM L	ALLEGHENY
CHAPPANO, PAUL J	STUDENT
CHARABATI, MD, JAY	LUZERNE
CHAREPOO, MD, KHASHAIAR	WARREN
CHARLES, MD, ROBERT S	MONTGOMERY
CHARLEY, MD, JOHN A	ALLEGHENY
CHARLSON, MD, MURRAY T	ALLEGHENY
CHARLTON, MD, BRIAN L	BRADFORD
CHARNEY, MD, RICHARD H	BUCKS
CHARNY, MD, CHARLES W	PHILADELPHIA
CHARRON, MD, MARTIN	ALLEGHENY
CHASE, MD, HAROLD F	PHILADELPHIA
CHASE, MD, JEFFREY S	PHILADELPHIA
CHASE, DO, RAYMOND D	FRANKLIN
CHASE, MD, WILLIAM D	CENTRE
CHASTENEY III, MD, EDWARD A	PHILADELPHIA
CHAT, MD, EMANUEL	PHILADELPHIA
CHATHA, MD, IFTIKHAR A	MERCER
CHATREE-DUANGNET, MD, CHAD	LAWRENCE
CHATWIN, AMBER L	STUDENT
CHATZINOFF, MD, MARTIN	MONTGOMERY
CHAUDHARI, MD, SUNITA N	ALLEGHENY
CHAUDHARY, MD, CHHAYA S	DELAWARE
CHAUDHRI, MD, MUNAWAR S	DELAWARE
CHAUDHRY, MD, MEHBOOB K	ALLEGHENY
CHAUDHRY, MD, MOHAMMAD A	MONROE
CHAUDHRY, MD, RAHAT M	ALLEGHENY
CHAUDHRY, MD, RAUF A	ALLEGHENY
CHAUHAN, MD, AMBARAM V	ALLEGHENY
CHAWLA, MD, HARISH C	BUCKS
CHAWLUK, MD, JOHN B	SCHUYLKILL
CHAYAPRUKS, MD, PRAYUN	GREENE
CHE, MD, KHANH	DELAWARE
CHECCHIO, MD, LEONARD M	MONTGOMERY
CHECK, MD, JEROME H	MONTGOMERY
CHEEVER, MD, FRANCIS S	ALLEGHENY
CHEIKIN, MD, MICHAEL I	MONTGOMERY
CHEKAN, MD, EDWARD G	STUDENT
CHELIUS, MD, ALAN S	BERKS
CHELLMAN, MELANIE R	STUDENT
CHEN, MD, ALEX S J	ALLEGHENY
CHEN, ANNA	STUDENT
CHEN, MD, ANNE	ALLEGHENY
CHEN, CHARLES T	STUDENT
CHEN, MD, CHIJEN	DELAWARE
CHEN, MD, DOUGLAS N	PHILADELPHIA
CHEN, MD, EDWARD C H	NORTHAMPTON
CHEN, MD, HENRY Y	VENANGO
CHEN, MD, ROBERT F	ALLEGHENY
CHEN, ROLAND S	STUDENT
CHEN, TAI-WEN	STUDENT
CHEN, TIMOTHY R	STUDENT
CHEN, MD, WEI-FAN	PHILADELPHIA
CHENEY, MD, MARYALICE	PHILADELPHIA
CHENG, MD, CHUN-PIN	ALLEGHENY
CHENG, CYNTHIA	STUDENT
CHENG, MD, DAVID T	ALLEGHENY
CHENG, MD, HARVEY S	LEHIGH
CHENG, MD, KENNETH P	ALLEGHENY
CHENG, MD, LAWRENCE C	LEHIGH
CHENG, MD, MEI-CHANG	BRADFORD
CHENGAPPA, MD, PALECANDA P	ALLEGHENY
CHENSEE, MD, JASPER G	BERKS
CHEPONIS, MD, GEORGE B	ALLEGHENY
CHERIAN, MD, R GEORGE	JEFFERSON
CHERN, MD, STEVEN A	WASHINGTON
CHERNEGA-SPIEKERMANN, MD, JOY	PHILADELPHIA
CHERNER, MD, RACHMEL	PHILADELPHIA
CHERNEY, MD, PAUL J	PHILADELPHIA
CHERNIAK, DAVID	STUDENT
CHERNOFF, MD, ARTHUR	PHILADELPHIA
CHERNOFF, MD, BENJAMIN	PHILADELPHIA
CHERNOFF, MD, ROBERT W	DELAWARE
CHERNOFSKY, MD, MICHAEL A	LEHIGH
CHERPES, MD, GREGORY L	ALLEGHENY
CHERRY, MD, KENNETH L	CENTRE
CHERRY, MD, LOUIS J	JEFFERSON
CHERRY, MD, MELANIE M	CENTRE
CHERRY, MD, SCOTT M	YORK
CHERRY, MD, STEVEN B	CUMBERLAND
CHERUP, MD, E DAVID	ALLEGHENY
CHERUP, MD, LORI L	ALLEGHENY
CHESEK, MD, LORRAINE M	ALLEGHENY
CHESEN, MD, DAVID	PHILADELPHIA
CHESEN, MD, NEIL	BERKS
CHESIN, MD, CAROLE M	ALLEGHENY
CHESNICK, MD, STEVEN R	MONTGOMERY
CHETLIN, MD, SHERWOOD M	ALLEGHENY
CHETLIN, MD, STUART H	ALLEGHENY
CHETT, MD, NICHOLAS J	BERKS
CHEVRES, MD, ANITA	MONTGOMERY
CHEYNEY II, MD, JAMES B	MONTGOMERY
CHI, MD, NUNGJA	PHILADELPHIA
CHIAO, MD, JOSEPH	BERKS
CHIAPELLA, MD, CARLA D	NORTHAMPTON
CHIARAMONTE III, MD, ANTHONY	STUDENT
CHIAVACCI, MD, ANTHONY L	LACKAWANNA
CHIAVACCI, MD, EUGENE J	LACKAWANNA
CHICKLO, MD, JAMES M	FRANKLIN
CHICO, MD, LAURO V	ALLEGHENY
CHIKARMANE, MD, AJIT M	LUZERNE
CHIKARMANE, MD, KALPANA A	LUZERNE
CHILDS, MD, ELIZABETH R	ALLEGHENY
CHILDS, MD, JOHN N	PHILADELPHIA
CHILDS, MD, MARION C	CHESTER
CHILDS, MD, ROBERT W	LUZERNE
CHILDS, MD, USHA M	PHILADELPHIA
CHIN, MD, BYOUNG KWON	BUCKS
CHIN, KATHLEEN L	STUDENT
CHINEA, MD, CARMEN	CAMBRIA
CHINITZ, MD, JOEL L	PHILADELPHIA
CHINSKY, MD, KENNETH D	ERIE
CHIRAYATH, MD, MERCY	BUCKS
CHIRIELEISON, MD, ROCCO F	BERKS
CHISHOLM, PATRICIA A	STUDENT
CHISOLM, OLETHIA E	STUDENT
CHISUM, MD, MELVIN J	PHILADELPHIA
CHITALE, MD, VIDYADHAR S	DELAWARE
CHIUMENTO, DO, NICHOLAS P	LACKAWANNA
CHIZEVER, GARY E	STUDENT
CHMIELEWSKI, MD, MICHAEL J	STUDENT
CHMIELEWSKI, MD, PAUL W	STUDENT
CHMIELEWSKI, MD, ROBERT E	PHILADELPHIA
CHO, MD, DOO W	BLAIR
CHO, MD, JAY J	DAUPHIN
CHO, MD, JONG S	FAYETTE
CHO, MICHAEL M	STUDENT
CHO, MD, YONG D	WASHINGTON
CHOBY, MD, JOHN J	BUCKS
CHODROFF, MD, CHARLES H	YORK
CHOGICH, MD, JOHN C	DELAWARE
CHOI, MD, EDWARD W	LUZERNE
CHOI, MD, HARRY H	CAMBRIA
CHOI, MD, JOHN K	PHILADELPHIA
CHOI, JOHN Y	STUDENT
CHOI, MD, KWANG Y	CRAWFORD
CHOI, MD, SAMUEL K	BRADFORD
CHOI, MD, SEAN H	ALLEGHENY
CHOI, MD, TOHSHIK	MONTGOMERY
CHOLAPRANEE, MD, REWAT	ALLEGHENY
CHOLHAN, MD, R C	LUZERNE
CHOLLAK, MD, WILLIAM L	PHILADELPHIA
CHOLLAK SR, MD, JOSEPH P	LUZERNE
CHOMSKY, MD, DAVID E	PHILADELPHIA
CHONG, MD, DANIEL C	ALLEGHENY
CHONG, MD, SUNGPOP	LEHIGH

CHOONG, MD, SHUNG S	SCHUYLKILL
CHOPRA, ANUJ K	STUDENT
CHOPRA, MD, RAJ P	COLUMBIA
CHORAZY, MD, ANNA J	ALLEGHENY
CHORAZY, MD, ZDZISLAW J	ERIE
CHORNEY, STEPHANIE K	STUDENT
CHORY, MD, EDWARD T	LANCASTER
CHOTINER, MD, BENNETT	DAUPHIN
CHOUGH, MD, ANDREW C B	ALLEGHENY
CHOUGH, MD, DENISE M	ALLEGHENY
CHOVANES, MD, GEORGE I	LEHIGH
CHOW, MD, HENRY Y	ALLEGHENY
CHOWDARY, MD, RAJ P	LEHIGH
CHOWDHRY, MD, ZAFAR I	ARMSTRONG
CHOWDHURY, MD, A RAB	BERKS
CHREKY, MD, EMILE H	ALLEGHENY
CHREMOS, MD, ATHANASSIOS N	PHILADELPHIA
CHRIST, MD, NICHOLAS J	BERKS
CHRIST, MD, PETER J	BERKS
CHRISTAKIS, MD, NICHOLAS A	PHILADELPHIA
CHRISTENSEN, MD, DAVID W	BERKS
CHRISTENSEN, DO, G CHRIS	MONTGOMERY
CHRISTIAN, MD, COLLEEN J	PHILADELPHIA
CHRISTIAN, MD, DEAN A	COLUMBIA
CHRISTIAN, MD, EUGENE P	WASHINGTON
CHRISTIAN, MD, HORACE D	ALLEGHENY
CHRISTIANSEN, DANA L	STUDENT
CHRISTIANSEN, MD, JEANNE M	ERIE
CHRISTIANSEN, GREGORY B	STUDENT
CHRISTIANSEN, MD, KJELL H	MONTGOMERY
CHRISTIANSON, MD, ALAN D	WESTMORELAND
CHRISTIDES, MD, STEPHAN A	PHILADELPHIA
CHRISTIE, MD, KARL B	ALLEGHENY
CHRISTIE, DO, PETER N	DELAWARE
CHRISTIE, MD, THOMAS	CHESTER
CHRISTIE, MD, WILLIAM C	ALLEGHENY
CHRISTIE JR, MD, ALFRED D	ALLEGHENY
CHRISTINE, DO, CRAIG R	LEHIGH
CHRISTMAN, MD, JAMES C	LEBANON
CHRISTMAN, MD, ROBERT A	PHILADELPHIA
CHRISTOFORETTI, MD, RUSSELL J	WASHINGTON
CHRISTOPHER, MD, KURT W	PHILADELPHIA
CHRISTOPHERSON, MD, WAYNE A	ALLEGHENY
CHRISTOU, MD, ARISTOTLE A	PHILADELPHIA
CHU, MD, ANN M	PHILADELPHIA
CHU, CHRISTINA S	STUDENT
CHU, MD, DONALD	PHILADELPHIA
CHU, MD, ELSIE H	PHILADELPHIA
CHU, MD, EVANGELINE	PHILADELPHIA
CHU, MD, JENNIFER	PHILADELPHIA
CHU, MD, WINSTON	ERIE
CHUA, MD, CHONG V	MONTGOMERY
CHUENSUMRAN, MD, ONGART	ALLEGHENY
CHUENSUMRAN, MD, RAJANI S	ALLEGHENY
CHUGHTAI, MD, ARSHAD I	ALLEGHENY
CHUGHTAI, MD, MUBASHAR S	ALLEGHENY
CHUI, CINDY	STUDENT
CHUKWUNENYE, MD, OBASI A	PHILADELPHIA
CHUN, MD, YOON-TAEK	MONROE
CHUNG, AUDREY M	STUDENT
CHUNG, MD, C KUN	LACKAWANNA
CHUNG, MD, CHIN D	LAWRENCE
CHUNG, MD, CHIN-YONG	ERIE
CHUNG, MD, EDWARD K	PHILADELPHIA
CHUNG, MD, HACK R	MONTGOMERY
CHUNG, MD, HI-YOUNG	LUZERNE
CHUNG, MD, INGRID I	PHILADELPHIA
CHUNG, MD, KI Y	ALLEGHENY
CHUNG, MD, KWANG H	ALLEGHENY
CHUNG, MD, LINDA C	PHILADELPHIA
CHUNG, RAYMOND K	STUDENT
CHUNG, MD, WHAN S	PHILADELPHIA
CHUNG, MD, WILLIS C	PHILADELPHIA
CHUNG, MD, YOON JIN	WESTMORELAND
CHUNN, MD, LIVINGSTON	PHILADELPHIA
CHURCH, MD, JEFFREY S	YORK
CIACCI, MD, VINCENT W	CHESTER
CIAMBOTTI, MD, GARY F	ALLEGHENY
CIANCIULLI, MD, FRANCIS D	DELAWARE
CIANFRANI, MD, PETER M	BUCKS
CIANNI, MD, RONALD J	LACKAWANNA
CIARALLO, MD, ROBERT L	ALLEGHENY
CIBIK, MD, LISA M	WASHINGTON
CICCARELLI, MD, CLEM A	YORK
CICCARELLI, MD, HAROLD E	ALLEGHENY
CICCARELLI, MD, LEE M	LYCOMING
CICCHINO, MD, FRANK E	ALLEGHENY
CICCO, MD, ROBERT C	ALLEGHENY
CICCOTELLI, MD, ALDO A	BUCKS
CICHELLI, MD, ANDREW V	PHILADELPHIA
CICHON, MD, PHILIP J	ALLEGHENY
CICILIONI JR, ORLANDO J	STUDENT
CICUTO, DO, ROBERT A	MERCER
CIFOR, DO, SANDRA M	FRANKLIN
CIGANIC, MD, RATIMIR R	ALLEGHENY
CIGNETTI, MD, FRANKLIN E	ALLEGHENY
CILIBERTI, MD, MICHAEL D	CHESTER
CINCALA, DO, ROBERT P	ALLEGHENY
CINCOTTA, DO, ANTHONY J	PHILADELPHIA
CINCOTTA, MD, JANET F	DAUPHIN
CINCOTTA, MD, JOSEPH A	DAUPHIN
CINDRICK, LORI L	STUDENT
CIOTOLA, MD, AUGUSTINE A	LUZERNE
CIOTOLA, MD, JOSEPH G	LUZERNE
CIOTOLA, MD, THOMAS J	LUZERNE
CIOTTI, DO, ANNETTE A	ALLEGHENY
CIPOLLA, MD, CHARLES F	LYCOMING
CIPRIANO, MD, JOHN J	LACKAWANNA
CIRELLI, MD, MARIO G	PHILADELPHIA
CIRELLY, DO, FRANCINE A	PHILADELPHIA
CIRIGLIANO, MD, DANIEL A	BUCKS
CIRIGLIANO, MD, MICHAEL D	PHILADELPHIA
CIRILLO JR, ROBERT L	STUDENT
CIRILLO-HYLAND, MD, VICTORIA A	PHILADELPHIA
CIROTTI, MD, JOSEPH J	MONTGOMERY
CIRUCCI, CHRISTINA A	STUDENT
CITRO, MD, LAURENCE A	BERKS
CITRONE, MD, PETER J	ALLEGHENY
CITTI, MD, JOHN G	LUZERNE
CIVITARESE, MD, LOUIS R	ALLEGHENY
CLADEL JR, MD, CHARLES E	DAUPHIN
CLADER, MD, STANLEY C	MONTGOMERY
CLAIR, MD, DAVID L	LEHIGH
CLANCY, MD, MICHAEL	PHILADELPHIA
CLARE, MD, DAVID W	ALLEGHENY
CLARE, MD, HENRY E	DELAWARE
CLARK, MD, ANN K	WESTMORELAND
CLARK, MD, DONALD L	PHILADELPHIA
CLARK, MD, FRANCIS J	MONTGOMERY
CLARK, MD, GRANT C	COLUMBIA
CLARK, MD, JAMES E	DELAWARE
CLARK, MD, JOSEPH D	STUDENT
CLARK, MD, JOSEPH M	LEBANON
CLARK, DO, KEVIN R	LANCASTER
CLARK, MD, LAWRENCE M	CLARION
CLARK, MD, LINDA J	ALLEGHENY
CLARK, MD, M DORCAS	INDIANA
CLARK, MD, MICHAEL L	BLAIR
CLARK, MD, NEIL R	LANCASTER
CLARK, MD, RICHARD E	ALLEGHENY
CLARK, MD, SHERYL	INDIANA
CLARK, MD, WILLIAM H	ALLEGHENY
CLARK JR, MD, GORDON H	ERIE
CLARKE, MD, CATHERINE F	MONTGOMERY
CLARKE, MD, CHARLES E	ALLEGHENY
CLARKE, DEBORAH A	STUDENT
CLARKE, MD, FRANKLYN R	BUCKS
CLARKE, MD, FREDERICK T	NORTHAMPTON
CLARKE, MD, JOHN R	PHILADELPHIA
CLARKE, MD, LEON E	PHILADELPHIA
CLARKE, MD, ROBERT H	ALLEGHENY
CLARKE, MD, SHEROL L	PHILADELPHIA
CLASSEN, MD, CAROLYN F	CUMBERLAND
CLASSEN, MD, CHARLES H	MONTGOMERY
CLAUHS, MD, RONALD P	CHESTER
CLAUSS, MD, THOMAS F	LACKAWANNA
CLAY, MD, BETTIE W	CHESTER
CLAY, MD, STEPHEN N	DELAWARE
CLAYTON, DO, JOHN S	CHESTER
CLAYTON, MD, RICHARD J	CHESTER
CLAYTON, MD, THOMAS D	CHESTER
CLAYTON JR, MD, SAMUEL T	DAUPHIN
CLEARFIELD, MD, HARRIS R	PHILADELPHIA
CLEARFIELD, MD, RONALD J	WESTMORELAND
CLEARFIELD, DO, WILLIAM N	LUZERNE
CLEAVER, MD, CLARENCE P	COLUMBIA
CLEAVER, MD, DOROTHY M	MONTGOMERY
CLEAVER, MD, E EUGENE	MONTGOMERY
CLELAN, MD, GEORGE M	LANCASTER
CLEMENS, MD, THOMAS M	LEBANON
CLEMENT, MD, GORDON S	MONTGOMERY
CLEMENT, MD, JOHN A	MONTOUR
CLEMENTS, MD, DAVID H	WESTMORELAND
CLEMENTS, MD, DAVID H	PHILADELPHIA
CLEMENTS, MD, JAMES K	WASHINGTON
CLEMENTS, MD, MICHAEL J	YORK
CLEMENTS, MD, WILLIAM T	BERKS
CLEMENTS, MD, WILLIAM W	MONTGOMERY
CLEPPER-FAITH, MD, MELISSA R	ALLEGHENY
CLEVENGER, MD, ROBERT W	ALLEGHENY
CLEVER, MD, JOHN E	ALLEGHENY
CLINE, MD, CHARLES W	ALLEGHENY
CLINE, MD, DOUGLAS C	LEHIGH
CLIPP, MD, SAMUEL W	BUCKS
CLISTA, MD, BRIAN T	STUDENT
CLOSE, MD, RICHARD A	BERKS
CLOSKEY, MD, GREGORY M	MONTGOMERY
CLOSSON, MD, EDWARD W	PHILADELPHIA
CLOUGH, MD, DOUGLAS F	ALLEGHENY
CLUTZ, MD, PAUL A	FRANKLIN
CLYMAN, MD, BYRON	MONTGOMERY
CLYMER, MD, DAVID G	BERKS
COADY, MD, PAUL M	CHESTER
COAR, MD, GEORGE R	LUZERNE
COATES JR, MD, JOHN B	CHESTER
COATS, THOMAS D	STUDENT
COBB, MD, BLAINE W	BRADFORD
COBBINAH, INGENUE F	STUDENT
COBERT, MD, HOWARD S	PHILADELPHIA
COBETTO, MD, BERNARD H	WESTMORELAND
COBLENTZ, MD, ROBERT H	ALLEGHENY
COCCO, MD, ALEX M	MERCER
COCHRAN, MD, JAMES F	NORTHAMPTON
COCHRAN, MD, WILLIAM C	MONTGOMERY
COCHRAN, MD, WILLIAM J	MONTOUR
COCHRANE, MD, PETER J	NORTHAMPTON
CODARIO, MD, RONALD A	PHILADELPHIA
CODELLA, MD, MARK S	PHILADELPHIA
CODISPOTI, MD, JOSEPH R	PHILADELPHIA
COFFEY, DO, DAVID	ERIE
COFFEY, MD, DAVID A	ALLEGHENY
COFFEY, MD, WILLIAM F	MONTGOMERY
COFFMAN, MD, KAOHLIN M	LYCOMING
COGEN, MD, FREDERICK C	MONTGOMERY
COGNETTI, MD, PETER A	LACKAWANNA
COHAN, MD, HAL D	MONTGOMERY
COHEN, DO, ALICE L	LANCASTER
COHEN, MD, ARCHIBALD C	BUTLER
COHEN, MD, BERNARD I	ALLEGHENY
COHEN, MD, BRUCE A	BERKS
COHEN, MD, CATHY S	ALLEGHENY
COHEN, MD, DANIEL J	BUCKS
COHEN, MD, DAVID A	PHILADELPHIA
COHEN, MD, DAVID E	MONTGOMERY
COHEN, MD, DAVID J	PHILADELPHIA
COHEN, MD, DAVID L	YORK
COHEN, MD, DEBORAH A	ALLEGHENY
COHEN, MD, DONALD L	MERCER
COHEN, MD, ERWIN A	PHILADELPHIA
COHEN, MD, FREDRIC L	CHESTER
COHEN, MD, H ELLIOTT	PHILADELPHIA
COHEN, MD, H EMMANUEL	PHILADELPHIA
COHEN, MD, IRA J K	ALLEGHENY
COHEN, MD, IVAN S	MONTGOMERY
COHEN, MD, J STANLEY	PHILADELPHIA
COHEN, MD, JACOB J	PHILADELPHIA
COHEN, DO, JEANNE M	PHILADELPHIA
COHEN, MD, JEFFREY K	ALLEGHENY
COHEN, JEFFREY S	STUDENT
COHEN, MD, KENNETH D	PHILADELPHIA
COHEN, MD, KENNETH R	PHILADELPHIA
COHEN, MD, LARRY K	ALLEGHENY
COHEN, DO, LAURIE A	LEHIGH
COHEN, MD, LEONARD M	ALLEGHENY
COHEN, MD, MARC C	MONTGOMERY
COHEN, MD, MARK H	MONTOUR
COHEN, MD, MARTIN A	BUCKS
COHEN, MD, MARTIN H	PHILADELPHIA
COHEN, MARY E	STUDENT
COHEN, MD, MELISSA D	PHILADELPHIA
COHEN, MD, MERTON E	NORTHAMPTON
COHEN, MD, MEYER A	PHILADELPHIA
COHEN, MD, MICHAEL M	PHILADELPHIA
COHEN, MD, MILTON H	MIFFLIN/JUNI
COHEN, MD, MITCHELL I	MONTGOMERY
COHEN, MD, MURRAY J	PHILADELPHIA
COHEN, MD, NORMAN F	PHILADELPHIA
COHEN, MD, NORMAN F	ALLEGHENY
COHEN, MD, NORMAN N	PHILADELPHIA
COHEN, MD, PETER Z	ALLEGHENY
COHEN, RANDOLPH B	STUDENT
COHEN, MD, RICHARD L	ALLEGHENY
COHEN, MD, ROBERT	NORTHAMPTON
COHEN, MD, ROBERT	BRADFORD
COHEN, DO, ROBERT A	ALLEGHENY
COHEN, MD, ROBERT M	PHILADELPHIA
COHEN, MD, SAMUEL F	MONTGOMERY
COHEN, MD, SARLE H	PHILADELPHIA
COHEN, MD, SHERWOOD V	PHILADELPHIA
COHEN, MD, STANLEY	PHILADELPHIA
COHEN, MD, STANLEY N	PHILADELPHIA
COHEN, MD, STEVEN S	FRANKLIN
COHEN, MD, THEODORE B	PHILADELPHIA
COHEN, MD, THOMAS	LUZERNE
COHEN, DO, WILLIAM L	DELAWARE
COHEN, MD, WILLIAM W	ERIE
COHEN, MD, YALE M	STUDENT
COHLER, MD, ALAN	MONTGOMERY
COHN, MD, BURTON H	DAUPHIN
COHN, MD, C HAROLD	BERKS
COHN, MD, EDWIN M	PHILADELPHIA
COHN, MD, HERBERT E	PHILADELPHIA
COHN, MD, JEFFREY B	PHILADELPHIA
COHN, MD, JOHN R	PHILADELPHIA
COLA, DO, CAROL D	LEHIGH
COLAIACOVO, LYNN A	STUDENT
COLANTONI, MD, WILLIAM	WASHINGTON
COLASANTE, MD, ANTHONY D	NORTHAMPTON
COLATRELLA, MD, ANTHONY M	ALLEGHENY
COLAVINCENZO, MD, JOHN W	BEAVER
COLBERG, MD, JAMES E	PHILADELPHIA
COLBURN JR, MD, HAROLD L	PHILADELPHIA
COLCHER, MD, IRVING S	MONTGOMERY
COLCHER, MD, ROBERT E	MONTGOMERY
COLDREN, MD, CAROL L	CHESTER
COLDREN, MD, ROBERT L	DAUPHIN
COLE, MD, CHARLES E	ALLEGHENY
COLE, MD, DANIEL J	ALLEGHENY
COLE, MD, DENNIS G	ERIE
COLE, DO, DERHYMERE L	MERCER
COLE, MD, JACK E	NORTHAMPTON
COLE, MD, JAMES M	MONTOUR
COLE, JOHN S	STUDENT
COLE, MD, K NIKI	PHILADELPHIA
COLE, EXEC DIR, MD, RICHARD S	WESTMORELAND
COLELLA, MD, MARK S	ALLEGHENY
COLEMAN, MD, DONALD K	NORTHAMPTON
COLEMAN, MD, ERNEST H	CENTRE
COLEMAN, MD, LINDA L	MONTOUR
COLEMAN, MD, MARTIN R	DELAWARE
COLEMAN, DO, MICHAEL H	BUTLER
COLEMAN, MD, THOMAS H	LACKAWANNA
COLEMAN JR, MD, ERNEST H	DAUPHIN
COLEMAN-BRACKEN, DO, BARBARA A	DELAWARE
COLETTA, MD, DANIEL J	BUCKS
COLIZZO, MD, FRANCIS P	PHILADELPHIA
COLLEY, MD, ALFRED L	PHILADELPHIA
COLLEY, MD, ARTHUR T	MONTOUR
COLLIER, MD, PAUL E	ALLEGHENY
COLLIER, MD, THOMAS F	DAUPHIN
COLLIER JR, MD, ANDREW J	PHILADELPHIA
COLLIN, MD, GARY R	DELAWARE
COLLINI, MD, FRANCIS J	LUZERNE
COLLINS, MD, FRANK J	YORK
COLLINS, MD, KENNETH P	CHESTER
COLLINS, MD, LAWRENCE A	ALLEGHENY
COLLINS, MD, LEONARD R	LYCOMING
COLLINS II, MD, J JOHN	LEHIGH
COLLINS JR, MD, RICHARD F	ALLEGHENY
COLLURA, MD, PAUL T	LANCASTER
COLMENAR, MD, ANTONIO B	PHILADELPHIA
COLMENARES, MD, RUPERTO F	BERKS
COLODNY, MD, STEPHEN M	ALLEGHENY
COLOMBO, MD, JAMES L	DELAWARE
COLT, MD, CATHY A	NORTHAMPTON
COLTMAN, MD, ARTHUR B	PHILADELPHIA
COLUMBUS, DO, LYNNE C	PHILADELPHIA
COLVIN, MD, VICTOR G	BEDFORD
COMAS, MD, MICHAEL G	CAMBRIA
COMBS, MD, WILLIAM G	PHILADELPHIA
COMER, MD, NATHAN L	PHILADELPHIA
COMESS, MD, RAYMOND R	BERKS
COMINI, MD, LIDIA	ALLEGHENY
COMSTOCK, MD, LLOYD K	ALLEGHENY
CONAHAN, MD, BERNARDIN Q	BUCKS
CONAHAN JR, MD, JOSEPH B	MONROE
CONAWAY, MD, BRUCE E	ALLEGHENY
CONCA, MD, DOMINICK M	MONTOUR
CONCILUS, MD, FRANK	ALLEGHENY
CONCOOL, MD, BARRY M	BUCKS
CONDIT, MD, BRIAN E	ALLEGHENY
CONDON, MD, GARRY P	ALLEGHENY
CONDON, MD, ROBERT H	DELAWARE
CONDRON, MD, BRIAN P	LANCASTER
CONE, MD, ALEXANDER S	ALLEGHENY
CONE, MD, DAVID C	PHILADELPHIA
CONE, MD, LIBBY	PHILADELPHIA
CONFORTI, MD, WILLIAM J	WESTMORELAND
CONGEDO, MD, CAROL Z	ALLEGHENY
CONKLIN, MD, JAMES E	ALLEGHENY
CONKLIN, MD, WILLIAM T	ALLEGHENY
CONLIN, MD, EDWARD F	MERCER
CONLY, MD, FRANK L	CLINTON
CONN, MD, ANDREW R	DELAWARE
CONN, MD, FRANK W	CAMBRIA
CONN, MD, WILLIAM V	ALLEGHENY
CONNAUGHTON, MD, JAMES F	CHESTER
CONNAUGHTON, MD, PATRICK N	LANCASTER
CONNELL, MD, JANET T	CHESTER
CONNELL, MD, THOMAS A	PHILADELPHIA
CONNELLY, MD, MICHAEL E	MERCER
CONNER, MD, GEORGE H	LEBANON
CONNER, MD, J HUBERT	CHESTER
CONNER, MD, KENNETH B	DAUPHIN
CONNERTON, MD, GEORGE E	BERKS
CONNOLE, MD, JOHN F	BLAIR
CONNOLLY, MD, DAVID P	ALLEGHENY
CONNOLLY, MD, MATTHEW J	PHILADELPHIA
CONNOLLY, DO, WILLIAM S	SCHUYLKILL
CONNOR, DO, J MICHAEL	FRANKLIN
CONNOR, MD, SUSAN A	CLARION
CONNORS, MD, CHARLES F	LACKAWANNA
CONNORS JR, MD, EARL K	BUCKS
CONO, MD, JOANNE	ALLEGHENY
CONRAD, MD, DONALD C	DAUPHIN
CONRAD, MD, JAMES L	BUCKS
CONRAD, MD, JOSEPH E	SCHUYLKILL
CONRAD, MD, REBECCA S	PHILADELPHIA
CONRAD, MD, WAYNE R	LANCASTER
CONRADY, MD, WILLIAM E	BEAVER
CONROY, DO, ELLEN D	CHESTER
CONROY, DO, JAMES F	PHILADELPHIA
CONROY, MD, JOSEPH V	PHILADELPHIA
CONROY, MD, WILLIAM P	ALLEGHENY
CONROY JR, DO, JOHN D	DAUPHIN
CONSEVAGE, MD, MICHAEL W	DAUPHIN
CONSOLI, MD, DEBORAH P	BERKS
CONSTANTIN, MD, LUIS	LEHIGH
CONSTANTINE, MD, GINGER D	DELAWARE
CONSTANTINE, MD, JAY J	DELAWARE
CONSTANTINESCU, MD, DANIEL E	PHILADELPHIA
CONTE, MD, ROBERT R	WESTMORELAND
CONTE, MD, THOMAS E	ALLEGHENY
CONTI, MD, JOSEPH D	CHESTER
CONTINO, MD, JOHN A	PHILADELPHIA
CONTOSTAVLOS, MD, DIMITRI L	DELAWARE
CONTRACTOR, MD, FARHAD M	ALLEGHENY
CONWAY, MD, CYRIL F	LYCOMING
CONWAY, MD, DONALD R	YORK
COOK, MD, DAVID G	PHILADELPHIA
COOK, MD, DAVID R	ALLEGHENY
COOK, MD, DONALD H	CHESTER
COOK, MD, ELIZABETH F	PHILADELPHIA
COOK, MD, JAMES A	MONTOUR
COOK, MD, NICHOLAS A	NORTHAMPTON
COOK, MD, PHILIP I	ALLEGHENY
COOK, MD, RALPH W	FAYETTE
COOK, MD, RANDALL C	WESTMORELAND
COOK, MD, RICHARD A	FAYETTE
COOK, MD, RICHARD P	BUCKS
COOK, MD, ROSEMARY A	PHILADELPHIA
COOK, MD, WILLIAM L	DELAWARE
COOK, MD, WILLIAM R	ALLEGHENY
COOK IV, MD, JOSEPH W	YORK
COOKE, MD, CURTIS W	VENANGO
COOKE JR, MD, ALFRED J	LANCASTER
COOKE JR, MD, W DONALD	BRADFORD
COOKSEY, MD, STEPHEN H	ALLEGHENY
COOLEY, MD, BETH A	ALLEGHENY
COOLIDGE, MD, WILLIAM A	TIOGA
COOPER, MD, COLLEEN A	MONROE
COOPER, MD, DAVID J	CHESTER
COOPER, MD, DAVID R	LUZERNE
COOPER, MD, DONALD R	PHILADELPHIA
COOPER, MD, EDWARD I	PHILADELPHIA
COOPER, MD, EDWARD S	PHILADELPHIA
COOPER, MD, EMMETT M	LANCASTER

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COOPER, MD, HARRY S PHILADELPHIA
COOPER, MD, HELEN C LUZERNE
COOPER, MD, HOMI S ERIE
COOPER, MD, JEANNE A ALLEGHENY
COOPER, MD, JOSEPH E LUZERNE
COOPER, MD, JOSEPH H DELAWARE
COOPER, MD, KAREN LUZERNE
COOPER, MD, KENNETH L LYCOMING
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COOPER, MD, MARK W PHILADELPHIA
COOPER, MD, MARTIN PHILADELPHIA
COOPER, MD, MAX M PHILADELPHIA
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COOPER, MD, SALLY A PHILADELPHIA
COOPER, MD, SUZANE C PHILADELPHIA
COOPER, MD, WILLIAM M ALLEGHENY
COOPER JR, MD, E NEWBOLD DELAWARE
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COORAY, MD, CHARLES N ALLEGHENY
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COPELAND, MD, G BRENT MONTOUR
COPELAND, MD, NATHANIEL H PHILADELPHIA
COPLEY, MD, LAWSON A PHILADELPHIA
COPPERMAN, MD, GERTRUDE PHILADELPHIA
COPPES, MD, CHARLES D PHILADELPHIA
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COPPOLA III, MD, MATTHEW J ALLEGHENY
COPPOLO, MD, BERNARD L ELK/CAMERON
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CORALLO, MD, DIANE M LANCASTER
CORAZZA, MD, LEO J LUZERNE
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CORCORAN, MD, JOHN J LANCASTER
CORCORAN, MD, MICHAEL J ALLEGHENY
CORDERO, MD, EDGAR C ALLEGHENY
CORDERO, MD, HERMELINDA LUZERNE
CORDOBA, MD, DIEGO R ARMSTRONG
CORDOVER, MD, ANDREW M PHILADELPHIA
COREN, MD, ALFRED B CLEARFIELD
COREN, MD, GARY S PHILADELPHIA
COREY, MD, STEPHEN H ALLEGHENY
CORFF, MD, MEYER PHILADELPHIA
CORKERY, DO, THOMAS B ALLEGHENY
CORKHILL JR, MD, ERIC A MONTGOMERY
CORMIER, DO, LESLIE L PHILADELPHIA
CORNACCHIA, DO, DAMIAN J DELAWARE
CORNACCHIONE, DO, MARIO J LUZERNE
CORNELL, MD, JAMES F LEHIGH
CORNELL, MD, LYNNE L ERIE
CORNFELD, MD, MARK J MONTGOMERY
CORNFIELD, MD, DENNIS B PHILADELPHIA
CORNMAN III, MD, HENRY D MONTGOMERY
COROSO, MD, JOSEPH G ALLEGHENY
CORPUZ JR, MD, MARCELO B ALLEGHENY
CORRADINO, MD, GREGORY CHESTER
CORRADO, MD, GAIL C CHESTER
CORRADO JR, MD, CATALDO F FAYETTE
CORRAL, MD, CELESTINO F ALLEGHENY
CORRELL, DARIN J STUDENT
CORRIGAN, MD, DOMINIC F MONTGOMERY
CORSON, MD, JOSEPH K PHILADELPHIA
CORSON, MD, STEPHEN L PHILADELPHIA
CORSON, MD, THOMAS C COLUMBIA
CORTEZA, MD, BENJAMIN A COLUMBIA
CORTINOVIS, MD, CHARLES R WASHINGTON
CORVASCE, MD, JOSEPH M PHILADELPHIA
CORWIN, MD, DOUGLAS T WASHINGTON
CORWIN JR, DOUGLAS T STUDENT
COSBY, MD, ROBERT L ALLEGHENY
COSENTINO, MD, MARK O BUCKS
COSGROVE, MD, DOUGLAS S PHILADELPHIA
COSGROVE, GREGORY P STUDENT
COSGROVE, MD, JAMES L ALLEGHENY
COSHAREK, MD, ROBERT F INDIANA
COSLETT, LYNNE M STUDENT
COSLETT, MD, MARTHA M Y LANCASTER
COSSROW, MD, JOEL I BEAVER
COSTA, MD, FRANK J ALLEGHENY
COSTA, MD, RONALD E HUNTINGDON
COSTACURTA, MD, GARY A NORTHAMPTON
COSTANTINO, MD, GEORGE N BUCKS
COSTANZA, MD, AGATHA H NORTHAMPTON
COSTARINO, MD, ANDREW T PHILADELPHIA
COSTELLO, MD, RALPH M WESTMORELAND
COSTELLO JR, MD, JOHN M MONTOUR
COTLER, MD, JEROME M PHILADELPHIA
COTLER, MD, MARC D MONTGOMERY
COTTER, JOHN T STUDENT
COTTINGTON, MD, G MALCOLM BUTLER
COTTLE, MD, BETTY L BLAIR
COTTLE, MD, HAROLD R BLAIR
COTTON, MD, VICTOR R LANCASTER
COTTRELL, MD, DAVID C NORTHMBRLAND
COUCH, MD, F BOYD WESTMORELAND
COULTER, MD, CLINTON R CLARION
COURBIN, MD, DAVID B LANCASTER
COURTNEY, MD, DENNIS J BEAVER
COURTNEY, MD, DREW E LEBANON
COURTNEY, MD, WILLIAM B WESTMORELAND
COUSOUNIS, MD, GERRY T PHILADELPHIA
COVALESKY, MD, VERONICA A PHILADELPHIA
COVATTO, MD, ROSEANN H STUDENT
COVER, MD, KENNETH L ALLEGHENY
COVERDALE, MD, PAUL J BUCKS
COVERDALE III, MD, EDWARD J BUCKS
COVINGTON, MD, DARELL T MONROE
COWAN, MD, JAMES A NORTHAMPTON
COWAN, MD, MICHAEL L LANCASTER
COWDERY, MD, SUSAN L PHILADELPHIA
COWEN, MD, DANIEL S PHILADELPHIA
COWGER, MD, DAVID L BRADFORD
COWITZ, MD, BERNARD PHILADELPHIA
COWLES, ROBERT A STUDENT
COWLEY, MD, ALLEN W DAUPHIN
COX, CONSTANCE A STUDENT
COX, DO, FRED A CHESTER
COX, MD, JACK L BEAVER
COX, MD, LAURIE A MIFFLIN/JUNI
COX, MD, N ADELE PHILADELPHIA
COX, MD, PAUL A CUMBERLAND
COX, MD, RALPH L FAYETTE
COX, MD, WALTER R WASHINGTON
COX-JONES, MD, CARLA L ALLEGHENY
COYLE, MD, JOHN J LUZERNE
COYLE, MD, ROBERT M ALLEGHENY
COYLE, MD, SOPHIE J ALLEGHENY
COYLE, MD, THOMAS J BUCKS
COYLE, MD, WILLIAM A DELAWARE
COYLE, MD, WILLIAM P ALLEGHENY
COYNE, MD, BONNIE A ALLEGHENY
COYNE, MD, VERONICA E BUCKS
COZEN, MD, BENNETT H MONTGOMERY
COZINE, MD, RICHARD A LYCOMING
COZZA JR, MD, MICHAEL R BEAVER
COZZARELLI, MD, JAMES D MONTGOMERY
COZZONE, DO, MONICA L LUZERNE
CRACKER, MD, ANDREW J MONTOUR
CRAGO, MD, H ROBERT MERCER
CRAIG, MD, ANN M PHILADELPHIA
CRAIG, MD, PAUL C BERKS
CRAIG, MD, RICHARD A YORK
CRAIN, MD, RICHARD H ALLEGHENY
CRAKE, MD, ROGER F COLUMBIA
CRAM, MD, ROBERT H DELAWARE
CRAMER, DO, DAVID I CENTRE
CRAMP, MD, LLOYD L BERKS
CRAMTON, MD, DAVID C LUZERNE
CRANDALL, MD, THEODORE L ALLEGHENY
CRANDALL, MD, TONIE L BERKS
CRANDALL III, MD, RICHARD A LANCASTER
CRANE, RICHARD D STUDENT
CRAPARO, MD, JOCELYN L DELAWARE
CRAPARO, MD, THOMAS J LACKAWANNA
CRASTNOPOL, MD, DAVID H BUCKS
CRAVETZ, MD, HOWARD MONTGOMERY
CRAWFORD, MD, CHERYL A ALLEGHENY
CRAWFORD, MD, DONALD G DAUPHIN
CRAWFORD, MD, GEORGE A FRANKLIN
CRAWFORD, MD, NANCY W DELAWARE
CRAWFORD, MD, PAUL H DAUPHIN
CRAWFORD JR, MD, RALPH W BLAIR
CRAWFORD-FAUCHER, AMY D STUDENT
CREARY, MD, PAUL J DAUPHIN
CREECH, MD, RICHARD H PHILADELPHIA
CREIGHTON JR, MD, DANIEL K MIFFLIN/JUNI
CRELL, DO, ANDREW M DELAWARE
CRESPO, DO, MANUEL O ERIE
CRETEKOS, MD, CONSTANTINE J ALLEGHENY
CRETELLA, MD, THOMAS S COLUMBIA
CREWS, DO, NAN I LEBANON
CRIBBINS III, A JOSEPH STUDENT
CRICHLOW, MD, AMRIL G ALLEGHENY
CRIDER, MD, DONALD B BLAIR
CRIEP, MD, LEO H ALLEGHENY
CRILL, MD, NORMAN C LANCASTER
CRILLEY, DO, PAMELA ANN PHILADELPHIA
CRINO, MD, JANET A PHILADELPHIA
CRISPEN, MD, JAMES F DAUPHIN
CRISPEN, MD, JOHN W ADAMS
CRISPINO, MD, CHARLES M ALLEGHENY
CRIST, MD, HENRY S CUMBERLAND
CRISTOL, MD, JAMES L PHILADELPHIA
CRITS, MD, HARRY J MONTGOMERY
CRITTENDEN, MD, DONALD W BUCKS
CRIVARO, MD, MICHAEL A MONTGOMERY
CROCCO, TODD J STUDENT
CROCK, MD, FREDERICK W ALLEGHENY
CROLEY, MD, JAMES T SCHUYLKILL
CROLL, MD, MILLARD N PHILADELPHIA
CRONIN, MD, DENNIS W PHILADELPHIA
CRONIN JR, MD, RANDALL C LUZERNE
CRONKEY, MD, JOSEPH E LACKAWANNA
CRONLEY, MD, SHEA ANN PHILADELPHIA
CROSS, MD, RAQUEL ERIE
CROSS JR, MD, SAMUEL ARMSTRONG
CROSSETT, MD, LAWRENCE S ALLEGHENY
CROTEAU, MD, J RUSSELL DAUPHIN
CROVELLO, MD, JOY ANN MARIE A MONTGOMERY
CROWE, DO, CHRISTOPHER C PHILADELPHIA
CROWLEY, KURT R STUDENT
CROWLEY, MD, PATRICIA A ALLEGHENY
CROYLE, MD, RAY W WESTMORELAND
CROYLE, EXEC SEC, LUANN ARMSTRONG
CROZIER, MD, KELLEY S PHILADELPHIA
CRUCIANI, MD, MARY C MONTOUR
CRUCIANI JR, MD, DOMINICK A LACKAWANNA
CRUDO, MD, CHITO M WESTMORELAND
CRUFT, MD, GEORGE E PHILADELPHIA
CRUMRINE, MD, RICHARD S BEAVER
CRUZ, MD, ALEXANDER C MONTGOMERY
CRUZ, DENISE A STUDENT
CRUZ, MD, EDGARDO S LEHIGH
CRUZ, MD, ROGELIO A ERIE
CRUZ JR, MD, MOISES B POTTER
CRYER, MD, THEODORE H FRANKLIN
CRYSTLE, MD, C DEANS LANCASTER
CSERNAK, MD, LASZLO J ALLEGHENY
CSIKOS, MD, DAVID A CAMBRIA
CSIR, MD, FLOYD M ERIE
CSUJA, GILBERT M STUDENT
CUBLER, MD, EDWARD W SCHUYLKILL
CUCINOTTA, MD, SALVATORE PHILADELPHIA
CUDDEBACK, MD, THOMAS J ALLEGHENY
CUDDY, MD, VINCENT D BEAVER
CULBERTSON, MD, CLAYTON E WASHINGTON
CULF, MD, NORRIS K PHILADELPHIA
CULIG, MD, CARL A ALLEGHENY
CULIG, MD, MICHAEL H ALLEGHENY
CULLEN, MD, ESKER W CENTRE
CULLEY, MD, ANDREW W BEAVER
CULOTTA, MD, DOMINIC A BUCKS
CULP, MD, BRUCE R MONTGOMERY
CUMMINGS, MD, ROBERT V ALLEGHENY
CUMMINGS III, MD, CARY DAUPHIN
CUNNANE, MD, MARY F PHILADELPHIA
CUNNINGHAM, MD, PETER L NORTHAMPTON
CUNNINGHAM, MD, WILLIAM L WASHINGTON
CUOMO, JEFF S STUDENT
CUPERMAN, MD, CINTIA M PHILADELPHIA
CUPINO, MD, ELMER CLEARFIELD
CURANZY, MD, RAYMOND R LEBANON
CURCI, MD, JOSEPH J BUCKS
CURLEY, DO, JOHN F PHILADELPHIA
CURLEY, DO, ROBERT M LACKAWANNA
CURRAN, MD, MARILYN R MONTGOMERY
CURRAN, PATRICK J STUDENT
CURRID, MD, AIDEEN M MONTOUR
CURRIE, MD, PHILIP W WESTMORELAND
CURRIE, MD, RICHARD J PHILADELPHIA
CURRY, HEATHER A STUDENT
CURRY, MD, THOMAS A SCHUYLKILL
CURTIN, MD, ANDREW J MONTGOMERY
CURTIN, MD, CHARLES T LACKAWANNA
CURTIN, MD, EUGENE A LACKAWANNA
CURTIN, MD, HUGH D ALLEGHENY
CURTIS, MD, BERNODETTE R PHILADELPHIA
CURTIS, MD, JAMES L MONTOUR
CUSTER, MD, CHRISTOPHER C MIFFLIN/JUNI
CUSTER, MD, DIANE E MONTGOMERY
CUSTODIO, MD, EDGARDO C LEHIGH
CUTHBERTSON, MD, RAND J CUMBERLAND
CUTILLI, MD, BRUCE J MONTGOMERY
CUTLER, MD, CHARLES MONTGOMERY
CUTLER, MD, IRVIN PHILADELPHIA
CUTLER, MD, JOHN C ALLEGHENY
CUTLER, MD, NEIL PHILADELPHIA
CUTLER, MD, ROBERT S CHESTER
CUTLER, MD, STANLEY M ALLEGHENY
CUTRY, MD, JOSEPH J POTTER
CUTULY, MD, EUGENE ALLEGHENY
CUY, MD, ROMULO M PHILADELPHIA
CUYEGKENG-JOSE, MD, CYNTHIA LUZERNE
CWIK, MD, JOHN C CAMBRIA
CYGAN, MD, DAVID J ALLEGHENY
CYNN, MD, WON S PHILADELPHIA
CYPHER, MD, RONALD L BUTLER
CYTRYN, MD, RICHARD A FRANKLIN
CZARNECKI, MD, CASIMIR PHILADELPHIA
CZARNECKI, MD, DOROTHY G PHILADELPHIA
CZUBA, MD, MICHAEL T WESTMORELAND

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D'AGATA, MD, SAMUEL D YORK
D'AGOSTINO, MD, VALENTINO LUZERNE
D'ALONZO, MD, WALTER A PHILADELPHIA
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D'AMICO, MD, ADRIAN A ALLEGHENY
D'AMICO, MD, ANTHONY V PHILADELPHIA
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D'IORIO, MD, JAMES P LUZERNE
D'ONOFRIO, MD, MATTHEW A STUDENT
D'ORSI, MD, ANGELA V PHILADELPHIA
D'URSO, MD, FRANCESCO CHESTER
DABB, MD, RICHARD W YORK
DABBACK, MD, DEWITT T CHESTER
DACOSTA, MD, JOHN B ALLEGHENY
DADDARIO, MD, RICHARD T BUCKS
DADI, MD, SHAUL S PHILADELPHIA
DADIAN, NISHAN STUDENT
DADPARVAR, MD, SIMIN D PHILADELPHIA
DAFTARY, MD, SUDHIR R LAWRENCE
DAGEN, MD, J EDWARD CUMBERLAND
DAGEN, DO, ROSE M FRANKLIN
DAGHESTANI, MD, AIMAN N CRAWFORD
DAGHIR, MD, JOHN N CHESTER
DAGLI, MERIH STUDENT
DAGOSTINO, MD, FRANK J NORTHAMPTON
DAHMUS, MD, ROBERT R DAUPHIN
DAIL, MD, ERIC M ERIE
DAILEY, MD, EDWARD G DAUPHIN
DAILEY, MD, ELLEN E ERIE
DAILEY, MD, JAMES P ERIE
DAILEY, STEPHEN W STUDENT
DAIT, MD, JOSE E CARBON
DAITER, MD, DONALD PHILADELPHIA
DAJANI, MD, ZUHDI M CLARION
DALAL, MD, NILOOFER F PHILADELPHIA
DALAL, MD, UMESH I MONROE
DALBOW, MD, MILTON R ALLEGHENY
DALBY, MD, PATRICIA L ALLEGHENY
DALE, MD, ANTHONY D PHILADELPHIA
DALE JR, MD, HIRAM T NORTHAMPTON
DALEY, MD, MARVIN C LANCASTER
DALONI, MD, PETER M MERCER
DALSIMER, DO, DAVID A YORK
DALTNER, MD, CARL J ALLEGHENY
DALTON, MD, BRIAN E CRAWFORD
DALTON, MD, CYNTHIA K ALLEGHENY
DALY, MD, CHRISTOPHER J ALLEGHENY
DALY, MD, CHRISTOPHER X MONTGOMERY
DALY, MD, DAVID G BERKS
DALY, MD, JOHN M PHILADELPHIA
DALY, MD, THOMAS J MONTGOMERY
DALY JR, MD, FRANCIS T CLINTON
DALY JR, MD, JAMES F DAUPHIN
DALY JR, MD, PETER F ALLEGHENY
DALY JR, MD, RICHARD H YORK
DAMAZO, MD, ELPIDIO D BEAVER
DAMAZO, MD, NATIVIDAD S BEAVER
DAMESHEK, MD, H LEE ALLEGHENY
DAMIANO, DO, JOHN A LANCASTER
DAMIANO, MD, MICHAEL D DELAWARE
DAMIANO, MD, ROBERT E CHESTER
DAMITZ, LYNN A STUDENT
DANAEE, MD, NOSRATOLLAH ALLEGHENY
DANAIE, MD, JAMSHID BEAVER
DANCHA, DO, ANDREW J PHILADELPHIA
DANDEGIAN, MD, ALBERT N PHILADELPHIA
DANDREA, MD, RAYMOND L CAMBRIA
DANES, MD, PETER M ALLEGHENY
DANFORTH, MD, NICHOLAS MONTOUR
DANG, MD, HOA T DELAWARE
DANGELO, MD, GEORGE J ERIE
DANIEL, DALTON R STUDENT
DANIELE, MD, JOSEPH Q ERIE
DANIELS, MD, DAN JEFFERSON
DANIELS, MD, FELICIA B STUDENT
DANIELS, MD, MICHAEL O CUMBERLAND
DANISHANKO, MD, ALBERT G LUZERNE
DANKMYER, MD, FREDERICK L SCHUYLKILL
DANKO, AILEEN M STUDENT
DANKO, MD, EUGENE T ALLEGHENY
DANNEKER, MD, DALE A CENTRE
DANNENBAUM, MD, MARK S PHILADELPHIA
DANNY, DO, MADELINE A MONTGOMERY
DANOFF, MD, DAVID M MONTGOMERY
DANOFF, MD, MIKE ALLEGHENY
DANTE, MD, STEPHEN J MONTGOMERY
DANTONIO, MD, JAMES A ALLEGHENY
DANYO, MD, J JOSEPH YORK
DANYO JR, J JOSEPH STUDENT
DANZIS, DO, JEFFREY J BUCKS
DAPPERT, MD, BARBARA A ALLEGHENY
DARDES, DO, NICHOLAS P LACKAWANNA
DARDIK, ALAN STUDENT
DARHUN, MD, BENJAMIN P SCHUYLKILL
DARNELL, MD, RICHARD I BUCKS
DAROWISH, DO, CHARLES E DAUPHIN
DARRAS, MD, FRANK S ALLEGHENY
DARRELL, MD, JOHN C ALLEGHENY
DAS, MD, AMIT LACKAWANNA
DAS, MD, NIRODE C LUZERNE
DAS, SAURABH B STUDENT
DASCHER JR, MD, JOHN J MONTGOMERY
DASH, MD, HOWARD ALLEGHENY
DASHE, MD, MYER M BERKS
DASHEIFF, MD, RICHARD M ALLEGHENY
DASTUR, MD, KHURSHED J ALLEGHENY
DATSKO, DEBORAH A STUDENT
DATTA, MD, BATYA P MONTGOMERY
DATTA, MD, TAPAN D WESTMORELAND
DATTILO, MD, JAMES T ALLEGHENY
DAUGHERTY, MD, DONALD YORK
DAUGHTRY, DO, GLEN R DAUPHIN
DAUM, MD, GARY S DELAWARE
DAURIA, MD, THOMAS M FAYETTE
DAVE, MD, BHAVIN R PHILADELPHIA
DAVE, MD, DEEPAK V LUZERNE
DAVE, MD, KAILAS D LUZERNE
DAVE, MD, NIKHIL K ALLEGHENY
DAVENPORT, MD, ARTHUR B WYOMING
DAVENPORT, ERIK C J STUDENT
DAVID, MD, ARTHUR ALLEGHENY
DAVID, MD, JEFFREY W ARMSTRONG
DAVIDES, MD, KYRIAKOS C ALLEGHENY
DAVIDHEISER, MD, SHARON I PHILADELPHIA
DAVIDOFF, MD, FRANK F PHILADELPHIA
DAVIDOWSKI, MD, THOMAS A CENTRE
DAVIDSON, MD, BRUCE L PHILADELPHIA
DAVIDSON, MD, GARY M CAMBRIA
DAVIDSON, MD, JAY H PHILADELPHIA
DAVIDSON, MD, PAUL R LANCASTER
DAVIDSON, MD, RICHARD S PHILADELPHIA
DAVIDSON, MD, STEVEN J PHILADELPHIA
DAVIDSON, MD, WALLACE L MONTGOMERY
DAVIDSON JR, MD, WILLIAM R LEBANON
DAVIE, MD, FRANK M WESTMORELAND
DAVIES, MD, ROBERT J BUCKS
DAVIES, MD, THOMAS E TIOGA
DAVILA, RENE STUDENT
DAVIS, ABBY T L STUDENT
DAVIS, MD, ALLAN S LANCASTER

DAVIS, MD, CAROLINE K DAUPHIN
DAVIS, MD, DANIEL T LUZERNE
DAVIS, MD, DENNIS WASHINGTON
DAVIS, MD, DONALD D ALLEGHENY
DAVIS, MD, DUANE E MONTOUR
DAVIS, MD, EARL C YORK
DAVIS, MD, EARLE R ALLEGHENY
DAVIS, MD, EDWARD W MONTGOMERY
DAVIS, MD, H ROBERT CUMBERLAND
DAVIS, MD, HAROLD J LACKAWANNA
DAVIS, MD, HARRIET J BUCKS
DAVIS, MD, HELEN A P WESTMORELAND
DAVIS, MD, IRENE B LANCASTER
DAVIS, MD, J MOSTYN MONTOUR
DAVIS, MD, JAMES H LANCASTER
DAVIS, MD, JAMES H YORK
DAVIS, MD, JAMES K CAMBRIA
DAVIS, MD, JOHN W PHILADELPHIA
DAVIS, DO, LEE W LACKAWANNA
DAVIS, MD, PAUL K DAUPHIN
DAVIS, MD, PETER L ALLEGHENY
DAVIS, MD, RAYMOND C SUSQUEHANNA
DAVIS, MD, ROBERT H DAUPHIN
DAVIS, MD, ROBERT M YORK
DAVIS, MD, SIDNEY UNION
DAVIS, MD, STEPHEN J DAUPHIN
DAVIS, MD, STUART M TIOGA
DAVIS, MD, THOMAS G PHILADELPHIA
DAVIS, MD, THOMAS S DAUPHIN
DAVIS, MD, WILLIAM F WAYNE/PIKE
DAVIS, MD, WILLIAM L FRANKLIN
DAVIS, MD, WILLIAM S DAUPHIN
DAVIS JR, MD, EDWARD T BEAVER
DAVIS JR, MD, ROBERT V LACKAWANNA
DAVITCH, MD, LEONARD S PHILADELPHIA
DAVOLI, MD, ROBERT L WESTMORELAND
DAWGERT, MD, F DENNIS LACKAWANNA
DAWSEY, MD, JOHN M BRADFORD
DAWSON, MD, MICHAEL H O SCHUYLKILL
DAWSON, MD, REESE E ALLEGHENY
DAY JR, MD, RICHARD W ALLEGHENY
DE, MD, NIRMAL K PHILADELPHIA
DE GUARDI, MD, MARY C ALLEGHENY
DE LEON, MARIA L STUDENT
DE MARTINIS III, MD, NICHOLAS A PHILADELPHIA
DE MARTINO, MD, PAUL J PHILADELPHIA
DE MASI, MD, ROCCO J YORK
DE MEJRA, MD, ELIO D MERCER
DE RIVAS, MD, CARMELA F MONTGOMERY
DE SANTIS, MD, DONALD DELAWARE
DE WITT, MD, WARREN S SUSQUEHANNA
DEAN, MD, ROBERT J ALLEGHENY
DEANGELIS, DO, PATRICIA A LEHIGH
DEANTONIO, MD, ANGELA M MONTOUR
DEARDORFF, MD, CHARLES L LANCASTER
DEAROLF III, MD, WALTER W MONTGOMERY
DEAS, MD, THOMAS C PHILADELPHIA
DEBACCO, PAUL STUDENT
DEBAKKER, MD, CAROL J DELAWARE
DEBENEDICTIS, MD, KENNETH J BERKS
DEBERARDINIS, MD, CAMILLO T PHILADELPHIA
DEBIAS, MD, DENNIS A MONTGOMERY
DEBIASSE, MD, TIMOTHY A WESTMORELAND
DEBONIS, MD, CHARLES S LUZERNE
DEBROFF, MD, BRIAN M ALLEGHENY
DECARLO, MD, JOHN P PHILADELPHIA
DECARO, MD, JOSEPH A DELAWARE
DECARO, MD, MARY M DELAWARE
DECARO, MD, MATTHEW V PHILADELPHIA
DECASTRO, MD, MIGUEL A PHILADELPHIA
DECASTRO, MD, NIEVES D PHILADELPHIA
DECHERNEY, MD, WILLIAM A PHILADELPHIA
DECHURCH, MD, FRANCES E MONTOUR
DECILLIS, MD, ARTHUR P ALLEGHENY
DECKER, MD, GARY R LUZERNE
DECKER, MD, JOHN P PHILADELPHIA
DECKER, MD, MICHAEL J ALLEGHENY
DECKER, MD, PETER G LUZERNE
DECKER, MD, RICHARD L BLAIR
DECKER, MD, STEVEN E MONTGOMERY
DECOSMO, MD, VINCENT J WESTMORELAND
DECURTIS, MD, GEORGE M LUZERNE
DEDHIA, MD, CHAMPAK LUZERNE
DEDIO, MD, ROBERT M LEHIGH
DEE, MD, CECILIO C MCKEAN
DEEB, MD, RAMON J LEHIGH
DEEMS, DANIEL A STUDENT
DEES-PORCH, MD, FRANCES DELAWARE
DEFALCIS, DANIEL C STUDENT
DEFAY, MD, STANLEY D BLAIR
DEFRANCESCO, MD, CHARLES A WESTMORELAND
DEFRANCISCO, MD, LANCE C BLAIR
DEFRANCISCO, MD, MARY E MONTGOMERY
DEFRANCO, MD, ALBERT B NORTHAMPTON
DEFRANCO, MD, JOSEPH M ERIE
DEGENNARO, MD, LOUIS P LACKAWANNA
DEGENNARO, MD, PATRICK J LUZERNE
DEGIOVANNI, MD, LESLEY ALLEGHENY
DEGIROLAMO, MD, MARIA P PHILADELPHIA
DEGLIN, MD, EDWARD A MONTGOMERY
DEGREEN, MD, HYATT P LANCASTER
DEGREGORIO, MD, NICHOLAS ALLEGHENY
DEGREGORY, DO, THOMAS R WESTMORELAND
DEGROOF, MD, ELLEN P L BUCKS
DEGRUTTOLA JR, DANIEL P STUDENT
DEGUZMAN-CAM, MD, BRIGIDA DELAWARE
DEHAAS, MD, DAVID R WASHINGTON
DEHART, MD, DAVID A ALLEGHENY
DEHORATIUS, MD, RAPHAEL F PHILADELPHIA
DEIBERT, MD, DAVID C BERKS
DEIBERT, MD, EDWARD B NORTHAMPTON
DEILY, MD, RAYMOND E NORTHAMPTON
DEIMEL, MD, JOSEPH F ERIE
DEIN, MD, ROBERT A MONTGOMERY
DEININGER, MD, JOHN T PHILADELPHIA
DEISHER, MD, SAMUEL W YORK
DEITCH, MD, BERNARD PHILADELPHIA
DEITCH, CHRISTOPHER W STUDENT
DEITCH, MD, MARC W PHILADELPHIA
DEITRICK, DAVID J STUDENT
DEITRICK, MD, JOHN E MONTOUR
DEITRICK, MD, RICHARD E ALLEGHENY
DEITRICK JR, MD, GEORGE A NORTHUMBERLAND
DEITZ III, MD, GEORGE W MONTGOMERY
DEITZLER, MD, MARGARET M PHILADELPHIA
DEJESUS, MD, ROBERT WESTMORELAND
DEJESUS JR, MD, ROMAN Y BEAVER
DEKONING, MD, JOHANNES L BLAIR
DEKRET, MD, JEFFREY J PHILADELPHIA
DEKRUIF, MD, HENDRIK CRAWFORD
DEL GALLO, MD, WALTER A PHILADELPHIA
DEL GIORNO, MD, JAMES J MONTGOMERY
DEL ROSARIO, ALEXANDER R STUDENT
DELA TORRE, MD, HENRY G JEFFERSON
DELACRUZ, MD, SILVESTRE S DAUPHIN
DELAFUENTE, MD, CARLOS F DAUPHIN
DELAPLANE, MD, JAMES M PHILADELPHIA
DELASALAS, MD, ERNESTO M BEDFORD
DELBIANCO, MD, PAUL R ALLEGHENY
DELCASTILLO, MD, JUAN J NORTHUMBERLAND
DELEHANTY, MD, THOMAS J LUZERNE
DELEO, MD, CAESAR A LACKAWANNA
DELEO, MD, NICHOLAS V LACKAWANNA
DELEO II, MD, CAESAR A LUZERNE
DELERME, MD, AUGUSTO N BLAIR
DELGADO, MD, JUAN F NORTHUMBERLAND
DELGATTO, MD, LOUIS J COLUMBIA
DELGRANDE, MD, RICHARD E BEAVER
DELGRIPPO, MD, GERARD A CLINTON
DELGUERCIO, MD, EDMUND T DELAWARE
DELL, MD, DAVID A CUMBERLAND
DELLA ROSA JR, MD, JOHN J LUZERNE
DELLA VALLE, CRAIG J STUDENT
DELLAVECCHIA, MD, MICHAEL A MONTGOMERY
DELLINGER, MD, KAY A CUMBERLAND
DELOGLOS, MD, GUST ALLEGHENY
DELONE, MD, CARRIE L DAUPHIN
DELONE, MD, J BRET DAUPHIN
DELONE JR, MD, CHARLES A DAUPHIN
DELONE JR, MD, FRANCIS X DELAWARE
DELONG, MD, BRIAN S DAUPHIN
DELONG, MD, STEPHEN R ALLEGHENY
DELONG JR, MD, WILLIAM G PHILADELPHIA
DELP, MD, DANIEL L HUNTINGDON
DELP, MD, RICHARD U COLUMBIA
DELP, MD, WILLIAM T YORK
DELP JR, MD, CHARLES W BERKS
DELROSARIO, MD, ROBERT G PHILADELPHIA
DELROSARIO, MD, VIVENCIO G DAUPHIN
DELSERONE, MD, EUGENE W ALLEGHENY
DELSERRA, MD, JOSEPH J LACKAWANNA
DELVADIA, MD, RASIKLAL N NORTHAMPTON
DELVECCHIO, MD, FREDERUINDA P BUCKS
DELVECCHIO, MD, LEONARD M BERKS
DELVECCHIO JR, MD, LEONARD M MIFFLIN/JUNI
DEMAIO, MD, RAYMOND STUDENT
DEMANGONE, MD, DAVID A ALLEGHENY
DEMANGONE, MD, MICHAEL J ALLEGHENY
DEMARCO, MD, CARLO M PHILADELPHIA
DEMARCO, MD, JOHN J ERIE
DEMARIA JR, MD, PETER A PHILADELPHIA
DEMARINO, MD, DAVID P ALLEGHENY
DEMARIO JR, MD, RALPH C LACKAWANNA
DEMASI, MD, PANTALEONE PHILADELPHIA
DEMATTEIS, MD, JAMES A ERIE
DEMEDIO, MD, GABRIEL A ALLEGHENY
DEMEDIO, MD, WILLIAM J DELAWARE
DEMEZZA, MD, ANGELO WESTMORELAND
DEMICHELE, ANDREW H STUDENT
DEMICHELE, MD, ANGELA M PHILADELPHIA
DEMILIO, MD, MARY T YORK
DEMJANENKO, MD, PAUL ERIE
DEMKO, MD, JOSEPH N LACKAWANNA
DEMOPOULOS, MD, JAMES T PHILADELPHIA
DEMOS, MD, JACK ALLEGHENY
DEMOURA, MD, JAMILO B PHILADELPHIA
DEMPSEY, MD, DANIEL T PHILADELPHIA
DEMPSEY, MD, EUGENE C PHILADELPHIA
DEMPSEY, MD, WILLIAM J LACKAWANNA
DEMPSHER, MD, JOHN CHESTER
DEMUTH, MD, CYNTHIA T DAUPHIN
DEMUTH, MD, WILLIAM W DAUPHIN
DEMUTH JR, MD, WILLIAM E CUMBERLAND
DENARO, MD, ANTHONY T LUZERNE
DENBY, MD, ROBERT A BERKS
DENCH JR, MD, EDWARD H CENTRE
DENDE, DO, PAUL F LACKAWANNA
DENGLER, MD, ERNEST H BERKS
DENIS, MD, LEONARD J LACKAWANNA
DENIZARD, MD, CARL E PHILADELPHIA
DENLINGER, MD, JOHN K LANCASTER
DENNEHY, MD, JOHN J MONTOUR
DENNIS, MD, JAMES B COLUMBIA
DENOVAN, MD, RICHARD E PHILADELPHIA
DENT, MD, THOMAS L MONTGOMERY
DEOL, MD, JASBIR S NORTHAMPTON
DEPACE, MD, NICHOLAS L PHILADELPHIA
DEPAMPHILIS, MD, HY J YORK
DEPAOLI, MD, ROSEMARY T COLUMBIA
DEPAULA, MD, CARL J PHILADELPHIA
DEPENA, MD, CHARLES A BUCKS
DEPILLIS, MD, VINCENT J MONTGOMERY
DEPP-HUTCHINSON, MD, WILLIAM S HUNTINGDON
DEQUEVEDO, MD, ROBERT F MONROE
DERASSE, MD, ALAIN R NORTHAMPTON
DERASSE, MD, JUDITH R NORTHAMPTON
DERENZO, MD, AURELIO G PHILADELPHIA
DEREWITZ, MD, DANIEL L YORK
DERIENZO, MD, UMBERTO A WASHINGTON
DERISO, MD, BARBARA M ALLEGHENY
DERIVAN, MD, ALBERT T DELAWARE
DERKRIKORIAN, MD, HAGOP L DELAWARE
DEROJAS, MD, JUAN J LUZERNE
DEROSIMO JR, JOHN F STUDENT
DERR, MD, CRAIG A BERKS
DERR, MD, FREDERICK S UNION
DERR, DO, JOSE F COLUMBIA
DERR, MD, RUSSELL H LANCASTER
DERRICK, MD, BRUCE M BUCKS
DERSH, MD, JEROME BERKS
DERSHAW, MD, BRUCE B BUCKS
DERSTINE, MD, RALPH L MONTGOMERY
DESAI, MD, AJIT M PHILADELPHIA
DESAI, MD, ANSUYA M MONTGOMERY
DESAI, MD, ARUNDEV D LACKAWANNA
DESAI, MD, ARVIND D LACKAWANNA
DESAI, MD, JAYESH B SOMERSET
DESAI, MD, JITENDRA M ALLEGHENY
DESAI, MD, KASHMIRA A LACKAWANNA
DESAI, MD, KIRITKUMAR T PHILADELPHIA
DESAI, MD, MEENA B LACKAWANNA
DESAI, MD, MOHAN G MONTGOMERY
DESAI, DO, PRAGNESH A LEHIGH
DESAI, MD, SARYU J ALLEGHENY
DESAI, MD, SHIRISHKUMAR B FAYETTE
DESAI, MD, SHIVRAJ J MONTGOMERY
DESANTIS, MD, LUIGI BUCKS
DESANTIS, MD, PETER L MERCER
DESANTOLA, MD, JOSEPH R PHILADELPHIA
DESHMUKH, MD, NARAYAN BRADFORD
DESHMUKH, MD, PRAMOD M BRADFORD
DESHPANDE, MD, ASHA S WARREN
DESHPANDE, MD, BHARADCHANDRA ERIE
DESHPANDE, MD, VILAS K LEHIGH
DESIDERIO, MD, ROBERT D PHILADELPHIA
DESIMONE, GARY A STUDENT
DESIMONE, MD, JOHN S WESTMORELAND
DESIMONE, RENEE A STUDENT
DESIO, MD, FELIX J BRADFORD
DESJARDINS, MD, GEORGE P BERKS
DESSEN, MD, EDGAR L LUZERNE
DETERS, MD, ROBERT L ALLEGHENY
DETHOFF, MD, JOHN C BERKS
DETHOMAS, MD, RONALD S MIFFLIN/JUNI
DETRE, MD, THOMAS ALLEGHENY
DETUERK, MD, JOHN J PHILADELPHIA
DETULLIO, MD, ANTHONY E PHILADELPHIA
DETWEILER, MD, THOMAS C MONTGOMERY
DETWEILER, EXEC DIR, JOHN S BUCKS
DEUTSCH, DO, JEROME C LEHIGH
DEUTSCH, MD, JOEL PHILADELPHIA
DEUTSCH, MD, MELVIN ALLEGHENY
DEUTSCH JR, MD, E THOMAS CHESTER
DEUTSCHMAN, MD, DANIEL A ALLEGHENY
DEVAN, MD, W TODD YORK
DEVANI, MD, SHYAMSUNDER H CARBON
DEVAUGHN, MD, GERALD L PHILADELPHIA
DEVENNEY, MD, JOHN E MONTGOMERY
DEVENUTO JR, MD, JOSEPH J BUCKS
DEVINE, MD, JEAN K MONTGOMERY
DEVINE, MD, MICHAEL F MONTGOMERY
DEVINE, MD, PETER J BUCKS
DEVINE, MD, RAYLENE A BERKS
DEVINE, MD, TERENCE M BRADFORD
DEVINEY, MD, JOHN P MONTGOMERY
DEVITA, MD, DENNIS M MIFFLIN/JUNI
DEVITA, MD, MICHAEL L MIFFLIN/JUNI
DEVITTORIO, MD, ARMOND A JEFFERSON
DEVOS, MD, KEITH J ALLEGHENY
DEVRIES, MD, JAN R J SOMERSET
DEVRYER, MD, JOHANNA M ALLEGHENY
DEWAN, MD, SANJIV PHILADELPHIA
DEWAR II, MD, WILLIAM R WAYNE/PIKE
DEWAR III, MD, WILLIAM R WAYNE/PIKE
DEWIS, MD, LESTER S CHESTER
DEX, MD, WALTER J LEHIGH
DEYSHER, DO, DAVID P INDIANA
DHADUK, MD, VITHALBHAI D LACKAWANNA
DHAGAT, MD, SATISHCHANDRA BEAVER
DHALIWAL, MD, DEEPINDER K ALLEGHENY
DHALIWAL, MD, RANJIT S ERIE
DHAWAN, MD, RAM L ALLEGHENY
DHAWER, MD, VIRENDER P S CAMBRIA
DHEEN, MD, MOHAMED H R LAWRENCE
DI GIOVINE, MD, NICK M ALLEGHENY
DIAKIW, MD, JOHN LACKAWANNA
DIAMANT, ALLISON STUDENT
DIAMANTONI, MD, STEPHEN G LANCASTER
DIAMOND, MD, B FRANKLIN MONTGOMERY
DIAMOND, MD, DANIEL L ALLEGHENY
DIAMOND, MD, HERBERT S ALLEGHENY
DIAMOND, MD, MARK ALLEGHENY
DIAMOND, MD, PAUL M WAYNE/PIKE
DIAMOND, DO, STEVEN M NORTHAMPTON
DIAZ, MD, FLORIEL P CARBON
DIAZ, MD, RENATO T LUZERNE
DIAZ, MD, RODOLFO LEBANON
DIAZ-RANGEL, MD, LUIS G NORTHAMPTON
DIBATTISTE, MD, PETER M PHILADELPHIA
DIBBERN JR, DONALD A STUDENT
DIBELLO, MD, ANGELO M PHILADELPHIA
DIBELLO JR, MD, JOSEPH N PHILADELPHIA
DIBENEDETTO, MD, THOMAS D LEHIGH
DIBERT, MD, LAWRENCE W BLAIR
DIBIASE, PAUL A STUDENT
DIBLASIO, JACQUELINE STUDENT
DICASIMIRRO, MD, JOHN A YORK
DICENZO, DO, FRANK D ALLEGHENY
DICENZO, MD, VALENTINA E STUDENT
DICHRISTINA, MD, DANIEL G ERIE
DICKENS, MD, HELEN O PHILADELPHIA
DICKEY, MD, ROBERT F MONTOUR
DICKINSON, MD, PETER A ALLEGHENY
DICKSON JR, MD, THOMAS B LEHIGH
DICKSTEIN, MD, BENJAMIN PHILADELPHIA
DICKTER, MD, STEVEN J CHESTER
DICOLA, MD, NANCY M ALLEGHENY
DICONCETTO, MD, JOSEPH A NORTHAMPTON
DICUCCIO, MD, NICHOLAS W CLINTON
DICUCCIO, MD, WILLIAM A BUTLER
DIDDLE, MD, KENNETH W WESTMORELAND
DIEDERICH, MD, CHARLES F ALLEGHENY
DIEFES, MD, GERARD J STUDENT
DIEHL, MD, STEVEN L BLAIR
DIENER, MD, IAN L MONTGOMERY
DIENHART, MD, KARL J BRADFORD
DIETEMAN, MD, DAVID F ERIE
DIETL, MD, CHARLES A MONTOUR
DIETLY, MD, ROBIN Z ALLEGHENY
DIETRICH, DO, LEONARD M BERKS
DIETRICH, DO, MALCOLM H YORK
DIETRICH, DO, MARCIA C BERKS
DIETRICH, MD, SCOTT A BERKS
DIETRICH, MD, WARREN C NORTHAMPTON
DIETRICK, MD, RONALD A BLAIR
DIEZ, MD, CHARLES M ALLEGHENY
DIFFENDERFER, DO, JUDITH E YORK
DIGERGORIO, MD, GUERINO J CHESTER
DIGIACOMO, MD, OSCAR P PHILADELPHIA
DIGIACOMO, MD, PAUL R LEBANON
DIGIACOMO JR, MD, PHILIP J MONTGOMERY
DIGILIO, MD, VICTOR A PHILADELPHIA
DIGIOVANNI, MD, ALPHONSE J DELAWARE
DIGIOVANNI, MD, VINCENT J LUZERNE
DIILIO, MD, RICHARD P ALLEGHENY
DIIORIO, MD, EMIL J NORTHAMPTON
DILCHER, MD, ROBERT H LEHIGH
DILEO, MD, DOMINIC W FAYETTE
DILEONARDO, MD, MARIO PHILADELPHIA
DILIBERTO, DO, THOMAS A DELAWARE
DILLA, MD, GARY J ALLEGHENY
DILLINGER, MD, ELLEN M ALLEGHENY
DILLON, MD, DANIEL J ALLEGHENY
DILLON, MD, MARY C PHILADELPHIA
DILLON, MD, RICHARD S MONTGOMERY
DILLON, MD, STEPHEN V ALLEGHENY
DIMAGGIO, MD, OLIVIA T DELAWARE
DIMAIO, MD, F H PAUL CLARION
DIMARCO, DO, ANTHONY E DELAWARE
DIMARCO, MD, ROSS F ALLEGHENY
DIMARINO, MD, ANTHONY J PHILADELPHIA
DIMASI, DO, ROBERT E ERIE
DIMAURO, MD, CYNTHIA L ALLEGHENY
DIMEGLIO, LINDA A STUDENT
DIMEN, MD, LAUREN A PHILADELPHIA
DIMEN, MD, LUIS PHILADELPHIA
DIMICK, MD, DEAN F LEHIGH
DIMICK, MD, ROBERT M ALLEGHENY
DIMILILER, MD, ISMAIL NORTHMBRLAND
DIMITSOPULOS, MD, DIMITRI ALLEGHENY
DIMOIA, MD, MARGARET M BUCKS
DIMONTE, MD, DIANE K CHESTER
DIMUN, MD, MICHAEL F ALLEGHENY
DINEEN, MD, FRANCIS A ALLEGHENY
DINGER, MD, JOHN M BLAIR
DINICOLA, MD, ARTHUR N SCHUYLKILL
DINON, MD, LOUIS R PHILADELPHIA
DINSMORE, MD, HARRY H JEFFERSON
DINUBILE, MD, NICHOLAS A PHILADELPHIA
DINULOS, MD, BALTAZAR T LEBANON
DION, MD, HARRY S PHILADELPHIA
DIORIO, MD, NORINA M LUZERNE
DIPIERRO, MD, FRANCIS V PHILADELPHIA
DIPIETRO, MD, DAVID E BUCKS
DIPPERY, MD, LEE M BLAIR
DIPPOLITO, MD, ANTHONY D NORTHAMPTON
DIRENZO, MD, DENNIS P BERKS
DIRIENZO, MD, ENRICO J BUCKS
DIRNBERGER, DO, THOMAS SCHUYLKILL
DIROCCO, MD, VINCENT P PHILADELPHIA
DISALVO, MD, BARBARA A NORTHAMPTON
DISALVO, MD, EUGENE I NORTHAMPTON
DISANDRO, DANIEL G STUDENT
DISCHMAN, MD, ELAINE C BUTLER
DISESA, MD, VERDI J PHILADELPHIA
DISHART, MD, PAUL W ALLEGHENY
DISILVESTRO, MD, HELEN E PHILADELPHIA
DISILVESTRO JR, MD, JOHN M A PHILADELPHIA
DISILVIO, MD, THOMAS V LACKAWANNA
DISTEFANO, MD, GRIMALDO C PHILADELPHIA
DITANO II, ORIENTE STUDENT
DITARANTO, MICHAEL A STUDENT
DITLOW JR, MD, RICHARD J CUMBERLAND
DITMARS, MD, DOUGLAS D NORTHAMPTON
DITOPPA, DO, LOUIS A ALLEGHENY
DITRE, MD, CHERIE M PHILADELPHIA
DITTMAN, MD, THOMAS H LUZERNE
DITTMAR, NYRA M STUDENT
DITTRICH, DO, RICHARD J PHILADELPHIA

DITUNNO, MD, JOHN F	PHILADELPHIA
DIWAN, MD, KANTA	DELAWARE
DIWAN, MD, SATYENDRA K	DELAWARE
DIX JR, MD, ROBERT C	UNION
DIXIT, MD, NIRANJAN D	FAYETTE
DIXON, MD, GARRETT W	VENANGO
DIXON, MD, HAROLD L	PHILADELPHIA
DIXON, MD, RICHARD H	CENTRE
DIXON, MD, ROBERT E	MIFFLIN/JUNI
DIZON, MD, GAUDENCIO S	CARBON
DJERASSI, MD, ADY L	PHILADELPHIA
DLIN, MD, BARNEY M	PHILADELPHIA
DLUTOWSKI, MD, BERNARD J	PHILADELPHIA
DLUZANSKY, MD, JAMES J	BLAIR
DOAN, PHUONG-ANH T	STUDENT
DOBAY III, KAROLY J	STUDENT
DOBHAN, RICHARD R	STUDENT
DOBISH, MD, MARK P	FRANKLIN
DOBKIN, MD, LARRY A	ALLEGHENY
DOBKIN, MD, STEPHEN F	DELAWARE
DOBLER, MD, JAMES C	ALLEGHENY
DOBLER, MD, LEE C	ALLEGHENY
DOBROSKY, MD, JOSEPH D	NORTHAMPTON
DOBROTA, MD, JOHN S	BUCKS
DOBSON, MD, ANDRE L	BLAIR
DOCKTOR, MD, JOHN W	YORK
DODD, MD, STEPHEN I	MIFFLIN/JUNI
DODDS, MD, H THOMAS	DELAWARE
DODGE, MD, HERBERT C	PHILADELPHIA
DODSON, MD, DONALD L	NORTHAMPTON
DODSON, MD, STEVEN R	NORTHAMPTON
DOE, MD, ROBERT G	LANCASTER
DOEBLER, MD, ROBERT W	ALLEGHENY
DOENECKE, MD, ARTHUR L	LANCASTER
DOERFLER JR, MD, FREDERICK B	ARMSTRONG
DOFT, MD, BERNARD H	ALLEGHENY
DOHAD, MD, SUHAIL Y	PHILADELPHIA
DOHERTY, MD, JAMES L	PHILADELPHIA
DOHERTY, JOHN C	STUDENT
DOHERTY, DO, JOHN M	DELAWARE
DOHERTY, MD, JOSEPH C	WESTMORELAND
DOHERTY JR, MD, HENRY J	MONTGOMERY
DOHERTY JR, MD, JOHN H	LACKAWANNA
DOHERTY SR, MD, JOHN H	LACKAWANNA
DOLAN III, MD, JAMES J	CLINTON
DOLAND, MD, CHERYL A	YORK
DOLBERG, MD, BEVERLY K	STUDENT
DOLFMAN, MD, VICTOR	PHILADELPHIA
DOLINSKAS, MD, CAROL A	PHILADELPHIA
DOUTSKY, MD, JAY N	ALLEGHENY
DOLL JR, MD, ROBERT B	LEHIGH
DOLLINS, MD, STEPHEN C	ALLEGHENY
DOLPHIN, MD, JOHN M	PHILADELPHIA
DOLSKY, MD, RICHARD L	MONTGOMERY
DOMAT, MD, IMAD	ALLEGHENY
DOMBKOSKI, MD, RUTH A	DELAWARE
DOMERACKI, GARY F	STUDENT
DOMESEK, MD, JAMES M	PHILADELPHIA
DOMIANO, MD, STEVEN F	PHILADELPHIA
DOMINGO, MD, ORVILLE H	DELAWARE
DOMINICK, MD, THOMAS F	STUDENT
DOMIT, MD, JOHN	WESTMORELAND
DONAHOE, MD, MICHAEL T	FRANKLIN
DONAHUE, MD, JOHN R	MONTGOMERY
DONALDSON, DO, GORDON R	SCHUYLKILL
DONALDSON, MD, JAMES B	PHILADELPHIA
DONALDSON, MD, WILLIAM F	ALLEGHENY
DONALDSON III, MD, WILLIAM F	ALLEGHENY
DONAN, MD, ANDERSON W	MERCER
DONATELLI, MD, JOHN M	ALLEGHENY
DONATO, ANDREW R	STUDENT
DONATO, DO, ROBERT A	LYCOMING
DONCASTER, MD, RICHARD M	WESTMORELAND
DONDE, MD, DILIP M	CAMBRIA
DONDE, MD, MRUNALINI D	CAMBRIA
DONEKER, MD, THOMAS G	NORTHAMPTON
DONER, DO, IVAN A	PHILADELPHIA
DONG, MD, MAI-LI	ALLEGHENY
DONLEY JR, MD, CHARLES M	ALLEGHENY
DONNELLY, MD, BRIAN W	ALLEGHENY
DONNELLY JR, MD, JOSEPH C	BERKS
DONNER, MD, WILLIAM T	MONTGOMERY
DONOFRIO, MD, ROBERT J	ALLEGHENY
DONOHUE, MD, BRYAN C	ALLEGHENY
DONOVAN, MD, ALTHEA A	LANCASTER
DONOVAN, MD, BYRON L	WESTMORELAND
DONOVAN, MD, FRANCIS C	ALLEGHENY
DONOVAN, MD, JOHN J	ALLEGHENY
DONOVAN, MD, MARY E	PHILADELPHIA
DONOVAN, MD, ROBERT J	ALLEGHENY
DONOVAN, MD, ROBERT J	LACKAWANNA
DONOVAN, MD, ROBERT S	ERIE
DONROVICH, MD, PAUL J	CAMBRIA
DONSHIK, JON D	STUDENT
DOO, MD, GERALD K	ADAMS
DOOLEY, MD, JOHN M	YORK
DOOLEY, MD, THOMAS W	BERKS
DORAZIO, MD, DOMINICK J	LANCASTER
DORAZIO, DO, RONALD J	DELAWARE
DORFMAN, MD, ALAN M	MONTGOMERY
DORFMAN, MD, MICHAEL	PHILADELPHIA
DORFMAN, MD, MURRAY L	DELAWARE
DORI, EZRA M	STUDENT
DORIAN, MD, ALAN L	MONTGOMERY
DORION, MD, ROBERT P	MONTOUR
DORKO, MD, CARL J	DAUPHIN
DORMAN, MD, GORDON	PHILADELPHIA
DORMAN, MD, SANFORD A	NORTHAMPTON
DORNENBURG, MD, JAMES R	ALLEGHENY
DORNSTEIN, MD, PERRY I	MONTGOMERY
DORO, MD, LOUIS C	PHILADELPHIA
DORRELL, MD, SEAN G	CHESTER
DORSCH, MD, CAROLE A	YORK
DORSCH, VERONICA C	STUDENT
DORSCH JR, MD, RAYMOND M	LEBANON
DORSEY, DENISE M	STUDENT
DORSEY, MD, JAMES T	LEHIGH
DORSHIMER, MD, GARY W	PHILADELPHIA
DORVAL, MD, JANE	LEHIGH
DORVILLE, MD, FABIO L	NORTHAMPTON
DORWART, MD, BONNIE B	PHILADELPHIA
DOSHI, MD, KIRTI K	PHILADELPHIA
DOSHI, MD, NALINI N	ALLEGHENY
DOSHI, MD, NARENDRA S	ALLEGHENY
DOSHI, NIPA R	STUDENT
DOSTAL, MD, JULIE A	LUZERNE
DOTO JR, MD, JOSEPH B	NORTHAMPTON
DOTSEY, MD, MICHAEL T	CLEARFIELD
DOTTERER, MD, CHRISTINE S	NORTHUMBERLAND
DOTTOR, MD, ALBINKA J	LEHIGH
DOTTS, EXEC SEC, CAROL	CHESTER
DOUDS, MD, HOWARD N	ALLEGHENY
DOUGHERTY, ELIZABETH A	STUDENT
DOUGHERTY, MD, JANET M	ALLEGHENY
DOUGHERTY, MD, MALVIN J	PHILADELPHIA
DOUGHERTY, MD, RALPH N	ALLEGHENY
DOUGHERTY III, DO, JOHN E	DAUPHIN
DOUGHTY, DO, PAUL F	JEFFERSON
DOUGLAS, BARBARA S	STUDENT
DOUGLAS, MD, DONALD D	UNION
DOUGLAS, MD, RICHARD A	ALLEGHENY
DOUGLASS, MD, PAUL H	YORK
DOUGLASS JR, MD, WILLIAM T	DAUPHIN
DOUPE, MD, DAVID W	ERIE
DOVNARSKY, MD, JAMES H	PHILADELPHIA
DOVNARSKY, MD, MICHAEL K	LUZERNE
DOVYDAITIS, MD, ROMAS	LACKAWANNA
DOWDELL, MD, PAUL J	MERCER
DOWHAN, MD, THOMAS P	PHILADELPHIA
DOWINSKY, MD, STEVEN K	PHILADELPHIA
DOWLING, MD, JOHN J	PHILADELPHIA
DOWLING, MD, KEITH J	DAUPHIN
DOWLUT, MD, MOHAMMAD N	BLAIR
DOWNES, MD, JOHN J	PHILADELPHIA
DOWNIE, MD, ROBERT W	PHILADELPHIA
DOWNING, MICHAEL J	STUDENT
DOWNING, MD, TIMOTHY M	CRAWFORD
DOWNS, DO, CAROLYN R	BUCKS
DOWNS, MD, HELEN E	ALLEGHENY
DOWNS JR, LEVI S	STUDENT
DOYLE, MD, ALFRED P	ALLEGHENY
DOYLE, MD, FAYE R	CHESTER
DOYLE, MD, HARRY A	PHILADELPHIA
DOYLE, MD, HOWARD R	ALLEGHENY
DOYLE, MD, JOHN J	ALLEGHENY
DOYLE, MD, RUSSELL G	CHESTER
DRABYK, CHRISTINE E	STUDENT
DRACOS, MD, FRANK J	MONROE
DRAGAN, MD, GEORGE A	ALLEGHENY
DRAGANESCU, MD, JOHN M	DELAWARE
DRAGANOSKY, MD, EUGENE A	BUCKS
DRAGON, MD, GLENN M	PHILADELPHIA
DRAGONETTI, MD, GERALD C	PHILADELPHIA
DRAIN, MD, RANDALL T	PHILADELPHIA
DRAKES, MD, GEORGE H	BERKS
DRANOV, MD, JONATHAN	CENTRE
DRAPCHO-FOTI, MD, CONNIE	PHILADELPHIA
DRAPER, MD, NELLE E	PHILADELPHIA
DRAPIEWSKI, MD, JOHN F	LUZERNE
DRATCH, MD, MICHAEL B	PHILADELPHIA
DRATLER, MD, M BRUCE	CRAWFORD
DRATMAN, MD, CATHY K	PHILADELPHIA
DREER, MD, AARON M	PHILADELPHIA
DREHER, MD, ROBERT H	NORTHAMPTON
DREIBELBIS, MD, WILLIAM H	CENTRE
DREIFUS, MD, LEONARD S	PHILADELPHIA
DRENCHKO JR, MD, PETER	INDIANA
DRENNEN JR, MD, JAMES K	BUTLER
DRESSEL JR, MD, CHRISTOPHER J	LACKAWANNA
DREW, MD, FRANCES L	ALLEGHENY
DREZNER, MD, MALCOLM E	BUCKS
DREZNIN, MD, STEPHEN	ALLEGHENY
DRINKER, MD, HENRY M	PHILADELPHIA
DRISCOLL, MD, GENEVRA Z	MONTGOMERY
DRIZIN, MD, GARY S	MONTGOMERY
DRODER, MD, ROBERT M	BRADFORD
DROMERICK JR, MD, ALEXANDER W	PHILADELPHIA
DROZDIAK, MD, RUSSELL A	INDIANA
DRUBETSKY, MD, NORMAN	PHILADELPHIA
DRUCKMAN, MD, STEPHEN M	LEBANON
DRUFFNER JR, MD, LEWIS C	LACKAWANNA
DRUMMOND, MD, DENIS S	PHILADELPHIA
DRY, MD, FREDERICK A	LEHIGH
DSILVA, MD, HENRY I	BUCKS
DUA, MD, JAYANT K	CHESTER
DUA, MD, RUP K	ALLEGHENY
DUANE, MD, THOMAS D	NORTHAMPTON
DUBEY, MD, BAROJ K	ERIE
DUBIN, MD, WILLIAM R	PHILADELPHIA
DUBLIN, MD, GEORGE J	PHILADELPHIA
DUBNER, MD, PAUL F	ALLEGHENY
DUBOWITZ, MD, LESLIE	SCHUYLKILL
DUBROVSKY, MD, OLGA	ALLEGHENY
DUCA, MARK A	STUDENT
DUCA, MD, PETER R	PHILADELPHIA
DUCH, MD, PETER M	PHILADELPHIA
DUCKETT, MD, JAMES E	DELAWARE
DUCKETT JR, MD, JOHN W	PHILADELPHIA
DUCKO, CHRISTOPHER T	STUDENT
DUDA, MD, ANDREW M	BERKS
DUDA, MD, JOHN R	ERIE
DUDECK, MD, CARL R	BUTLER
DUDEK, MD, ARKADIUSZ Z	DAUPHIN
DUDENHOEFER, MD, CHRISTIAN P	ERIE
DUDENHOEFER, MD, FREDERICK J	ERIE
DUDENHOEFER, MD, KATHLEEN M	ERIE
DUDLEY, CLARISSA M	STUDENT
DUDZINSKI, DO, JOHN E	ERIE
DUE, MD, CHRISTOPHER F	YORK
DUER, MD, NATHAN B	GREENE
DUERKSEN, MD, ROGER L	ALLEGHENY
DUFFIELD, MD, THOMAS E	BUCKS
DUFFY, MD, CLYDE F	ALLEGHENY
DUFFY, MD, RUTH E	CHESTER
DUFFY, MD, SCOTT S	BERKS
DUFFY, MD, TERENCE F	LUZERNE
DUGAN, MD, CHARLES T	WESTMORELAND
DUGAN, LINDY L	STUDENT
DUGAN, MD, THOMAS M	ERIE
DUGAN JR, MD, THOMAS M	BEAVER
DUGGAN, MD, JAMES H	ALLEGHENY
DUGGAN JR, MD, FRANCIS J	DAUPHIN
DUGGER, MD, DOROTHY E	PHILADELPHIA
DUKE II, MD, LEE M	LANCASTER
DUKE III, MD, BRUCE E	CAMBRIA
DUKER, MD, DANIEL G	ALLEGHENY
DULA, MD, DAVID J	MONTOUR
DULABON, MD, DAVID A	ERIE
DULABON, MD, GEORGE M	ALLEGHENY
DULL, MD, JAMES A	WESTMORELAND
DUMARAN, MD, DELFA G	MONTGOMERY
DUMAS, MD, PETER A	PHILADELPHIA
DUMPE, MD, KEVIN C	BEAVER
DUMPE, MD, PAMELA M	BEAVER
DUNAGIN, MD, WILLIAM G	VENANGO
DUNAY, DO, DARLENE A M	LACKAWANNA
DUNCAN, MD, CARL R	YORK
DUNCAN, MD, JAMES R	ALLEGHENY
DUNCAN, MD, RALPH E	YORK
DUNCAN, MD, THEODORE G	PHILADELPHIA
DUNCOMBE, MD, MICHAEL P	ERIE
DUNFEE, MD, ROBIN A	LANCASTER
DUNHAM, DO, DOUGLAS A	ALLEGHENY
DUNKELBERGER, MD, JOHN A	CENTRE
DUNKLE, MD, DAVID B	DAUPHIN
DUNN, MD, DAVID D	ERIE
DUNN, MD, GEOFFREY P	ERIE
DUNN, MD, JAMES C	PHILADELPHIA
DUNN, MD, JEANETTE C	PHILADELPHIA
DUNN, MD, JEFFREY M	PHILADELPHIA
DUNN, MD, JEROME	LEHIGH
DUNN, MD, JOSEPH P	VENANGO
DUNN, MD, LINDA K	PHILADELPHIA
DUNN, DO, LORI	DAUPHIN
DUNN, MD, PHILIP F	HUNTINGDON
DUNNE, MD, GAY D	CENTRE
DUNNE, MD, JAMES H	CENTRE
DUNNING, MD, E RUTH	MONROE
DUNSKY, MD, ELIOT H	PHILADELPHIA
DUPLER, MD, DONALD A	PHILADELPHIA
DUPONT JR, MD, PHILIP J	CLEARFIELD
DUPRE', MD, MARCEL W	MONTOUR
DUPREE, MD, BETH B	PHILADELPHIA
DUPREY, MD, JAMES G	LANCASTER
DUQUE-PAGES, MD, HELENA	ALLEGHENY
DURBACK, MD, MARK A	NORTHAMPTON
DURBECK, MD, DONALD C	DAUPHIN
DURGIN, MD, BERNICE E	CENTRE
DURHAM, SUSAN R	STUDENT
DURICK, MD, THOMAS W	CRAWFORD
DURISEK, MD, GEORGE S	DAUPHIN
DURKAN JR, MD, GERALD	ALLEGHENY
DURKIN, MD, DAVID J	CENTRE
DURKIN, DO, JANE E	LUZERNE
DURKIN, MD, MAUREEN L	ADAMS
DURKIN, MD, RAYMOND A	LEHIGH
DURNAN, MD, ROSEMARY	ALLEGHENY
DURNING, MD, ROBERT P	ALLEGHENY
DUROCHER, MD, JOHN R	PHILADELPHIA
DURRWACHTER, MD, KENNETH R	ALLEGHENY
DURRWACHTER, MD, ROBERT J	LYCOMING
DUSENBERRY, MD, SARAH J	BEAVER
DUTTA, MD, TARIT K	ALLEGHENY
DUTTON, TIMOTHY E	STUDENT
DUZY, MICHAEL J	STUDENT
DVORCHAK, MD, MATTHEW J	CAMBRIA
DVORIN, MD, DONALD J	PHILADELPHIA
DVORKIN, MD, DANIEL	CHESTER
DWECK, MD, MONICA M	LEHIGH
DWORETZ, MD, APRIL R	ALLEGHENY
DWORKIN, DO, GERALD E	PHILADELPHIA
DWYER, MD, JOHN H	ALLEGHENY
DY, MD, ERNESTO Y	ELK/CAMERON
DY, MD, JACQUELINE G	PHILADELPHIA
DY, MD, JOHNNY R	PHILADELPHIA
DYCKMAN, MD, SHARON	BUCKS
DYE, MD, ROBERT E	DAUPHIN
DYKYJ JR, MD, ROMAN	PHILADELPHIA
DYNAN, MD, JAMES E	MONTGOMERY
DYREYES, MD, ROBERTO R	LEBANON
DYSON, MD, WILLIAM L	PHILADELPHIA
DZIALOWSKI, MD, KENNETH J	FAYETTE
DZWONCZYK JR, MD, JOHN	PHILADELPHIA
E	
EAGEN, MD, JEREMIAH W	LACKAWANNA
EAGER, MD, J MICHAEL	BERKS
EAGLE, MD, PERRY A	YORK
EARLE, MD, MARTIN F	ALLEGHENY
EARLE-BROWN, MD, JOYLEEN E	PHILADELPHIA
EARLY, MD, CALVIN B	FRANKLIN
EARLY JR, MD, ROBERT F	BERKS
EARLY SR, MD, ROBERT F	LEBANON
EARNEST, MD, TAMAR D	LEHIGH
EASLER, MD, RICHARD E	ALLEGHENY
EASTMAN, MD, LAURA B	ALLEGHENY
EATER JR, MD, CHARLES L	MIFFLIN/JUNI
EATON, MD, DAVID A	NORTHAMPTON
EATON, MD, EDWARD H	DAUPHIN
EBERHART, MD, JOSEPH C	BUCKS
EBERLY, MD, DAVID E	DELAWARE
EBERSOLE, MD, JOHN H	LANCASTER
EBERSOLE, MD, THOMAS M	BERKS
EBERZ, MD, DENNIS A	ALLEGHENY
EBY, MD, CARL E	SOMERSET
ECHENBERG, MD, ROBERT J	NORTHAMPTON
ECHIKSON, MD, EDWARD H	MONTGOMERY
ECKBERG, MD, JOHN J	ERIE
ECKEL, MD, TIMOTHY B	COLUMBIA
ECKELS, DO, DENNIS L	CAMBRIA
ECKENRODE, MD, JOSEPH L	LANCASTER
ECKER, MD, ANDREW M	MONTGOMERY
ECKER, MD, MALCOLM L	PHILADELPHIA
ECKER JR, MD, HERBERT A	LYCOMING
ECKER SR, MD, HERBERT A	LYCOMING
ECKERT, MD, ROBERT T	BUTLER
ECKROTH, MD, RICHARD N	LEBANON
EDDINGER, MD, LEO C	LEHIGH
EDELMAN, MD, BARRY J	YORK
EDELMANN, MD, CHRISTINE A	ALLEGHENY
EDELSTEIN, MD, ABE J	CAMBRIA
EDELSTEIN, MD, JOEL K	PHILADELPHIA
EDELSTEIN, MD, NORMAN L	ALLEGHENY
EDER JR, MD, GEORGE E	YORK
EDGE, MD, FRED C	FAYETTE
EDINGER, MD, ANDREW M	UNION
EDINGTON, MD, JOHN M	PHILADELPHIA
EDMISTON, MD, ROBERT B	DAUPHIN
EDMOND, MD, MICHAEL B	ALLEGHENY
EDMUNDOWICZ, MD, ALPHONSE C	DAUPHIN
EDMUNDOWICZ, MD, DANIEL	PHILADELPHIA
EDMUNDS, MD, ELIZABETH H	BERKS
EDWARDS, MD, ANITA	ALLEGHENY
EDWARDS, MD, GEORGE E	DAUPHIN
EDWARDS, MD, MARY D	ALLEGHENY
EDWARDS, MD, TODD D	ALLEGHENY
EDWARDS, MD, WILLIAM M	ALLEGHENY
EDWARDS, MD, WILLIAM P	VENANGO
EELKEMA, MD, ELIZABETH A	ALLEGHENY
EFFINGER, MD, GEROLD J	BUCKS
EFFINGER-KASSOW, MD, ELLEN B	PHILADELPHIA
EGAN, MD, CHRISTINE L	STUDENT
EGBERT, MD, E WAYNE	DELAWARE
EGGLER, MD, BETSEY A	MIFFLIN/JUNI
EGLICK, MD, PAUL G	PHILADELPHIA
EGOVILLE, MD, CHARLES R	PHILADELPHIA
EHGARTNER, DO, GREG R	DAUPHIN
EHLY, MD, GEORGE W	CUMBERLAND
EHMANN, MD, CARL W	BUCKS
EHRHART, TROY J	STUDENT
EHRLICH, MD, CLIFFORD L	MONTGOMERY
EHRLICH, MD, FRANK	PHILADELPHIA
EHRLICH, MD, GEORGE E	PHILADELPHIA
EHRLICH, MD, LEONARD D	MONTGOMERY
EHYA, MD, HORMOZ	PHILADELPHIA
EIBLING, MD, DAVID E	ALLEGHENY
EICHER, MD, WENDELL P	BUCKS
EICHLER, MD, GEORGE R	NORTHAMPTON
EICHMILLER, MD, JOHN P	ALLEGHENY
EICHNER, MD, LAMBERT G	DELAWARE
EILER, MD, WILLIAM A	ALLEGHENY
EILERS, MD, STEVEN G	BUCKS
EINHORN, MD, KENNETH H	MONTGOMERY
EISEN, MD, CAROLE L	DELAWARE
EISEN, MD, HOWARD B	ALLEGHENY
EISENBEIS JR, MD, CARL H	ALLEGHENY
EISENBERG, MD, FLOYD P	MONTGOMERY
EISENBERG, MAUREEN E	STUDENT
EISENBERG, MD, RICHARD B	ERIE
EISENHARDT, DO, BRUCE T	NORTHAMPTON
EISENHOWER, MD, EDWARD A	LANCASTER
EISENHOWER-TURNER, MD, EDITH S	DELAWARE
EISENSTADT, MD, NORMAN	PHILADELPHIA
EISMAN, MD, SYLVAN H	PHILADELPHIA
EISNER, MD, ABRAHAM G	LACKAWANNA
EISNER, MD, JOEL W	CHESTER
EISNER, MD, STEVEN B	LACKAWANNA
EKBERG, MD, NORMAN L	MONTOUR
EL-ATTAR, SUZANNE M	STUDENT
EL-ATTRACHE, MD, MAMDOUH F	WESTMORELAND
EL-ATTRACHE, MD, SELIM	WESTMORELAND
EL-BORNO, MD, BASSAM M A	LANCASTER
EL-HILLAL, MD, MOHAMMAD F	WESTMORELAND
ELATTAR, MD, ANAS A	ALLEGHENY
ELCOCK, MD, CLAUDIUS A	PHILADELPHIA
ELDAIEF, MD, DAISY S	MONTGOMERY
ELDER, MD, E GLENN	NORTHAMPTON
ELDER, MD, JAY E	JEFFERSON
ELEFANT, MD, HOWARD L	PHILADELPHIA
ELENITSAS, MD, ROSALIE	PHILADELPHIA
ELES, DO, GUSTAV R	ALLEGHENY
ELFMAN, MD, LOUIS K	PHILADELPHIA
ELIA, MD, EUGENE A	DELAWARE
ELIADES, MD, WILLIAM	PHILADELPHIA
ELIAS, MD, FARID J	WESTMORELAND

ELIAS, MD, STANTON B	ALLEGHENY
ELIGATOR, MD, JULIAN	ALLEGHENY
ELKIN, DO, RICHARD J	LANCASTER
ELKINS, MD, CAROL G	CLEARFIELD
ELKO, BARBARAANNE C	STUDENT
ELLEN, MD, STEPHEN J	PHILADELPHIA
ELLENBERGER JR, MD, CARL	LEBANON
ELLER, MD, ANDREW W	ALLEGHENY
ELLIOTT, MD, FREDERICK W	MCKEAN
ELLIS, MD, CHRISTINA E	CHESTER
ELLIS, MD, DAVID J	DELAWARE
ELLIS, MD, DAVID M	MONTGOMERY
ELLIS, MD, DAVID W	LEBANON
ELLIS, MD, DIANA E	BRADFORD
ELLIS, MD, GEORGE L	ALLEGHENY
ELLIS, MD, HERMAN M	PHILADELPHIA
ELLIS, MD, LAWRENCE D	ALLEGHENY
ELLIS, DO, LOUIS D	SCHUYLKILL
ELLIS, MD, PETER G	ALLEGHENY
ELLIS, MD, RICHARD A	PHILADELPHIA
ELLIS, EDD EXEC DIR, U BERKLEY	MONTGOMERY
ELLIS IV, MD, JOHN H	LUZERNE
ELLIS JR, MD, LEANDER T	PHILADELPHIA
ELLISON, MD, JAMES H	YORK
ELLISON, MD, JULIUS	PHILADELPHIA
ELLISON, MD, MARYJANE	ALLEGHENY
ELLISON, MD, NEIL M	MONTOUR
ELLISON, MD, NORIG	MONTGOMERY
ELLISON JR, MD, RICHARD T	MONTGOMERY
ELMALEH, MD, MIRIAM K	PHILADELPHIA
ELMER, MD, EDWARD M	ALLEGHENY
ELMORE, MD, JAMES R	MONTOUR
ELNOUR, MD, MOHAMED F	DAUPHIN
ELOVIC, MD, ELIE P	WASHINGTON
ELSAWY, MD, MAGDY M	ALLEGHENY
ELSTROM, REBECCA L	STUDENT
ELTON, SCOTT W	STUDENT
ELVIR, MD, RAMON	WARREN
ELYADERANI, MD, MORTEZA K	BEAVER
ELYAN, MD, MOHAMED I	YORK
ELZENEINY, MD, ISMAIL H	NORTHAMPTON
EMAMI, ELIZABETH R	STUDENT
EMANUEL, MD, ABRAHAM	BEAVER
EMANUEL, MD, E STEPHEN	DELAWARE
EMANUEL, ERIC R	STUDENT
EMANUELSON, MD, RICHARD G	LACKAWANNA
EMERSON, MD, JOHN A	VENANGO
EMERY, MD, ROBERT C	NORTHAMPTON
EMKEY, MD, KENNETH D	BERKS
EMKEY, MD, RONALD D	BERKS
EMMOLO, MD, ALFONSE A	VENANGO
EMPER, MD, WILLIAM D	MONTGOMERY
ENANY, MD, ALBERT K	FAYETTE
ENCKE, MD, TED K	ALLEGHENY
ENDER, PETER T	STUDENT
ENDERS, BELINDA G	STUDENT
ENDERS, MD, JOHN G	FRANKLIN
ENDRES, MD, JAY E	WARREN
ENDRES, MD, WARREN H	LEHIGH
ENEANYA, MD, DENNIS I	MONTGOMERY
ENG, CATHY	STUDENT
ENGEL, MD, EDWARD E	ERIE
ENGEL, MD, GREGORY S	ERIE
ENGEL, MD, ROBERT	LUZERNE
ENGLE, MD, DAVID J	ALLEGHENY
ENGLE, MD, EUGENE K	LANCASTER
ENGLE, MD, HAROLD H	LEBANON
ENGLE, MD, JOSEPH H	FRANKLIN
ENGLISH, DAVID K	STUDENT
ENGLISH, MD, DENNIS H	ALLEGHENY
ENGLISH, MD, JAMES B	BLAIR
ENGLISH, MD, JOSEPH G	LYCOMING
ENGLISH, MD, O SPURGEON	PHILADELPHIA
ENGLISH, MD, RICHARD B	LUZERNE
ENGLISH, MD, ROBERT S	FAYETTE
ENGLISH JR, MD, WALTER E	CLINTON
ENGSTROM, MD, PAUL F	PHILADELPHIA
ENNIS, MD, MICHAEL F	ALLEGHENY
ENNIS, PETER D	STUDENT
ENRIQUEZ, MD, DANILO L	ALLEGHENY
ENTERLINE, MD, HORATIO T	PHILADELPHIA
ENTINE, MD, JOSEPH H	PHILADELPHIA
ENTWISTLE, MD, NELSON L	DAUPHIN
ENYENIHI, MD, HENRY N	LUZERNE
ENZMAN, DO, PATRICIA M	LEHIGH
EPERJESSY, MD, ERNEST Z	CAMBRIA
EPISCOPIO, MD, JOSEPH V	NORTHAMPTON
EPPINGER, MD, MARY ANN	ALLEGHENY
EPPLEY, MD, MATTHEW J	PHILADELPHIA
EPSTEIN, MD, ALAN L	PHILADELPHIA
EPSTEIN, MD, BARRY E	PHILADELPHIA
EPSTEIN, MD, HERMAN	PHILADELPHIA
EPSTEIN, MD, ISADORE S	PHILADELPHIA
EPSTEIN, MD, KENNETH R	BUCKS
EPSTEIN, MD, PAUL E	PHILADELPHIA
EPSTEIN, MD, SCOTT K	PHILADELPHIA
ERB, DO, DONALD L	MONTOUR
ERB, MD, KATHLEEN M	ERIE
ERB JR, MD, WILLIAM H	DELAWARE
ERBSTEIN, MD, ROBERT A	ALLEGHENY
ERDEK JR, MD, MICHAEL A	BERKS
ERDMAN, MD, DANIEL E	PHILADELPHIA
ERHARD, MD, DANIEL T	MONTGOMERY
ERICKSEN, MD, JEFFERY J	DELAWARE
ERICKSON, MD, ELMER W	ALLEGHENY
ERKES, MD, NEAL	PHILADELPHIA
ERKI, LENKE	STUDENT
ERLICHMAN, MD, I FULTON	BUCKS
ERLICHMAN, DO, KATHERINE E	BEDFORD
ERMOLD, MD, DONALD R	BERKS
ERNST, MD, KAREN D	MONTOUR
ERNSTOFF, MD, BRIAN M	ALLEGHENY
ERSNER, MD, ARTHUR R	MONTGOMERY
ERSOZ, MD, CLARA J	ALLEGHENY
ERTEL, MD, D GREGORY	BERKS
ERVIN, MD, LAWRENCE M	BLAIR
ERWARD, MD, MICHAEL J	PHILADELPHIA
ERWAY, MD, PRESTON M	TIOGA
ERWIN, MD, HENRY K	NORTHAMPTON
ERWIN, MD, KATE M	ALLEGHENY
ESAA, MD, SHABDIR A	LYCOMING
ESBENSHADE II, MD, JOHN H	LANCASTER
ESCARO, MD, DANILO U	YORK
ESCHBACH, MD, EUGENIE M	BUCKS
ESCHBACH, MD, KELLY S	LEHIGH
ESHBACH, MD, TED S	DAUPHIN
ESHELMAN, DO, JOSEPH K	ALLEGHENY
ESHELMAN JR, MD, GUY R	LANCASTER
ESHLEMAN, MD, D ROHRER	LANCASTER
ESHLEMAN, MD, JOHN D	LANCASTER
ESHLEMAN, MD, S KENDRICK	LANCASTER
ESKAROUS, MD, NADY I	BERKS
ESKENDRI, MD, NASSER	BEAVER
ESKIN, MD, BERNARD A	PHILADELPHIA
ESKIN, MD, DAVID J	MONTGOMERY
ESKIN, ROSE N	STUDENT
ESKRIDGE, MD, TIMOTHY H	YORK
ESLER JR, MD, JAMES W	LEHIGH
ESPER, DO, ALAN N	ERIE
ESPER, DO, GARY F	ERIE
ESPER, DO, JEFFREY J	ERIE
ESPER, DO, ROBERT J	ERIE
ESPER, DO, RONALD A	ERIE
ESPER, DO, STEPHANY F	ERIE
ESPER, DO, WILLIAM A	ERIE
ESPOSITO, MD, FRANCIS A	ALLEGHENY
ESPOSITO, MD, JOHN C	DELAWARE
ESPOSITO, MD, JOSEPH P	DAUPHIN
ESQUENAZI, MD, ALBERTO	PHILADELPHIA
ESSIG, MD, MICHAEL J	ALLEGHENY
ESTOLANO, MD, MARIO G	ALLEGHENY
ESTORES JR, MD, DAVID S	ALLEGHENY
ESTRADA, MD, FERNANDO P	NORTHAMPTON
ESTRIN, MD, EDWARD H	BEAVER
ETNOYER, MD, JOHN J	LANCASTER
ETTENGER, MD, ALLEN B	HUNTINGDON
ETTENGER, MD, MORRIS S	PHILADELPHIA
ETTER, MD, RUSSEL H	YORK
ETTINGER, MD, JEFFREY B	PHILADELPHIA
ETTINGER, MD, STEVEN M	DAUPHIN
ETTLINGER, MD, ROBERT A	DAUPHIN
ETZEL, MD, KATHLEEN D	ALLEGHENY
EULIANO JR, MD, JOHN J	ERIE
EULIANO SR, MD, JOHN J	ERIE
EVANCHO, MD, CHARLES D	YORK
EVANGELISTA, MD, JESUS S	WASHINGTON
EVANGELISTA, MD, EMPLICIO E	MONTGOMERY
EVANS, MD, CHARLES M	LANCASTER
EVANS, MD, CYNTHIA K	ALLEGHENY
EVANS, MD, DAVID B	CUMBERLAND
EVANS, MD, DAVID M	CAMBRIA
EVANS, MD, DONALD E	ALLEGHENY
EVANS, MD, HAROLD H	UNION
EVANS, MD, HAYDEN O	MONTGOMERY
EVANS, MD, HILARY	CAMERIA
EVANS, MD, JAMES F	MONTOUR
EVANS, DO, JOHN C	CENTRE
EVANS, MD, JOHN J	CARBON
EVANS, MD, JONATHAN L	BUTLER
EVANS, JOSEPH B	STUDENT
EVANS, MD, JOSEPH B	PHILADELPHIA
EVANS, MD, ROBERT L	YORK
EVANS, MD, TERRY L	WESTMORELAND
EVANS, MD, THERMAN E	PHILADELPHIA
EVANS, MD, THOMAS M	ALLEGHENY
EVANS, MD, WILLIAM G	INDIANA
EVANS, EXEC SEC, ROBERT W	DAUPHIN
EVANS II, MD, LEWIS C	BRADFORD
EVARTS, MD, C MCCOLLISTER	DAUPHIN
EVERETT, MD, WILLIAM G	ALLEGHENY
EVERHART, MD, CHARLES W	MIFFLIN/JUNI
EVERHART, MD, WILSON C	DAUPHIN
EVERITT, MD, DANIEL E	PHILADELPHIA
EVRARD, MD, HELEN M	LANCASTER
EVRON, MD, WAYNE A	ALLEGHENY
EWALD, MD, JOHN L	ALLEGHENY
EWING, MD, AGNEW R	CHESTER
EWING, MD, CHARLES H	MONTGOMERY
EWING, MD, JAMES H	PHILADELPHIA
EWING, MD, MADELEINE Q	PHILADELPHIA
EWING, MD, STEPHANIE H	PHILADELPHIA
EXLEY, MD, WILLIAM B	BUCKS
EYERLY, MD, ROBERT C	MONTOUR
EYLER, MD, J ALBERT	BEDFORD
EYLER, MD, PAUL W	LANCASTER
EYVAZZADEH, MD, CAMILLE	NORTHAMPTON

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FABENS, MD, ELIZABETH L	PHILADELPHIA
FABER, JENNIE	STUDENT
FABER, MD, KALMAN	PHILADELPHIA
FABER, MD, MARK R	CHESTER
FABIAN, MD, ANDREW	NORTHUMBERLAND
FABIANI, MD, JOSEPH A	PHILADELPHIA
FABINYI, MD, GEZA T	BLAIR
FABIUS, MD, RAYMOND J	DELAWARE
FACCENDA, MD, DEBORAH R	BUCKS
FACKLER, MD, EMERSON F	DAUPHIN
FACKOVEC, MD, MICHAEL	WESTMORELAND
FADDEN, MD, ROBERT J	BEAVER
FAGELMAN, MD, KERRY M	DAUPHIN
FAGER, MD, JOSEPH S	DAUPHIN
FAGENBURG, MD, RODGER E	LACKAWANNA
FAGIOLETTI, MD, ROBERT J	WASHINGTON
FAHMY, MD, ANTHONY N	WESTMORELAND
FAHMY, MD, WASFY F	CHESTER
FAIL, MD, PETER S	PHILADELPHIA
FAILLA, MD, JACK P	ALLEGHENY
FAIRBROTHER, MD, MAUREEN E	DAUPHIN
FAIRBROTHER, MD, PAUL F	DAUPHIN
FAIRFIELD, MD, JAMES C	MONTGOMERY
FAIRWEATHER, MD, JACK L	UNION
FAKHRAEE, MD, MICHAEL S	PHILADELPHIA
FALANGA, MD, NATALE J	MONROE
FALASCA, DO, THOMAS D	ERIE
FALCHEK, STEPHEN J	STUDENT
FALCK, MD, JON D	PHILADELPHIA
FALCO, MD, FRANK G	BUCKS
FALCO, MD, FRANK J E	MONTGOMERY
FALCON JR, MD, JOSEPH R	ALLEGHENY
FALCONE, MD, DOMENICO	LEHIGH
FALGUERA, MD, DOMINADOR Q	DELAWARE
FALK, MD, ARTHUR E	MONTGOMERY
FALK, MD, EDWARD C	MERCER
FALK JR, MD, ROBERT B	LANCASTER
FALKENBERG, MD, K JORG	BRADFORD
FALKENBERG, MD, THOMAS	BRADFORD
FALKER, MD, JOHN M	MONTGOMERY
FALL, MD, MICHAEL H	BLAIR
FALLAHNEJAD, MD, MANOUCHER	PHILADELPHIA
FALLON III, MD, EDWARD C	BERKS
FALOR, MD, STANLEY E L	GREENE
FALUDI, MD, GEORGINA	PHILADELPHIA
FAN, MD, YOUNG C	VENANGO
FANELLI, DO, ANDREW T	BUCKS
FANELLI, MD, CLAUDE	DAUPHIN
FANELLI, MD, GREGORY C	MONTOUR
FANG, MD, JOHN Y	MONTGOMERY
FANG, MD, PETER J W	FRANKLIN
FANNING, DO, JOHN M	DELAWARE
FANNING, DO, ROBERT J	PHILADELPHIA
FARACE, MD, JOSEPH L	NORTHAMPTON
FARAGALLA, MD, RAMSES I	FRANKLIN
FARAH, MD, TONY G	ALLEGHENY
FARALLI, MD, VICTOR J	LEBANON
FARANO, MD, PETER J	PHILADELPHIA
FARB, MD, STANLEY N	MONTGOMERY
FARBER, MD, DAVID N	BERKS
FARBER, MD, EMANUEL P	PHILADELPHIA
FARBER, MD, ERIC S	BERKS
FARBER, MD, HAROLD F	PHILADELPHIA
FARBER, MD, HAROLD I	BERKS
FARD, MD, ALI K	PHILADELPHIA
FARIES, PETER L	STUDENT
FARIES JR, MD, GEORGE B	DAUPHIN
FARKAS, MD, ANDREW A	JEFFERSON
FARKAS, MD, BARRY L	ALLEGHENY
FARKAS, MD, ROBERT W	YORK
FARKOUH, MD, LISA J	PHILADELPHIA
FARMATI, MD, OSCAR	CRAWFORD
FARMER, DO, JOHN E	FRANKLIN
FARMER, MD, JOHN L	LANCASTER
FARMER, MD, LENORE	ALLEGHENY
FARNEY, MD, ESTHER S	ALLEGHENY
FARNON, MD, CHRISTA U	PHILADELPHIA
FARO, MD, ALBERT	ALLEGHENY
FARONE, DO, FRANK G	LAWRENCE
FARR, MD, JAMES	LEHIGH
FARR, MD, RUSSELL M	BEAVER
FARR, MD, STEPHANY D	PHILADELPHIA
FARRAH, DO, VICTOR B	CRAWFORD
FARRAR JR, MD, GEORGE E	PHILADELPHIA
FARRELL, MD, DOROTHY A	LUZERNE
FARRELL, MD, EDWARD L	ALLEGHENY
FARRELL, MD, LEO D	DAUPHIN
FARRELL, MICHAEL J	STUDENT
FARRELL, MD, PETER E	LEHIGH
FARRELL, MD, ROBERT E	LACKAWANNA
FARRELL, MD, TIMOTHY P	PHILADELPHIA
FARRELL, MD, TIMOTHY P	DAUPHIN
FARRELL, MD, WILLIAM J	LACKAWANNA
FARRINGTON, HOWARD H	STUDENT
FARRY, MD, KIMBERLY M	BERKS
FARZANFAR, MD, SUSAN	MONTGOMERY
FASANO, MD, M THERESA	YORK
FASANO, MARIA M	STUDENT
FASANO, MD, MICHAEL J	YORK
FASCIANA, MD, GUY M	LUZERNE
FASS, MD, BARRY D	BUCKS
FASS, MD, BONNIE L	PHILADELPHIA
FASSL, MD, JOSEPH J	LEHIGH
FAST, MD, WILLIS B	BUCKS
FATIGATI, MD, MARIO J	ALLEGHENY
FATULA, MD, GEORGE M	JEFFERSON
FATUR, MD, LEO M	ALLEGHENY
FAUST, MD, DONALD S	BERKS
FAUST, MD, HERBERT A	CHESTER
FAVA, MD, GEORGE E	LEBANON
FAVETTA, MD, MARCEL M	LUZERNE
FAVINI, MD, PETER J	MONROE
FAVINO, MD, C JAMES	MONTOUR
FAWCETT, MD, JAMES L	ALLEGHENY
FAYE, MD, ROBYN B	PHILADELPHIA
FAYNBERG, MD, MARK G	PHILADELPHIA
FAYNBERG, MD, NORA	MONTGOMERY
FAZI, MD, BURT	BLAIR
FAZIOLI, MD, LAWRENCE A	LAWRENCE
FEAR, MD, JESSE G	COLUMBIA
FEASTER, MD, MARSHALL M	BERKS
FECZKO, MD, WILLIAM A	ALLEGHENY
FEDDER, MD, STEPHEN L	DELAWARE
FEDELE, MD, CHARLES R	BRADFORD
FEDERICI, MD, VALERIO J	PHILADELPHIA
FEDERLE, MD, MICHAEL P	ALLEGHENY
FEDERMAN, MD, JAY L	DELAWARE
FEDEROFF, MD, SUSAN T	BEAVER
FEDOK, MD, FREDERICK G	DAUPHIN
FEDULLO, MD, LISA M	NORTHAMPTON
FEDUSKA, MD, RICHARD G	ALLEGHENY
FEE JR, MD, WILLIAM H	VENANGO
FEEHAN, MD, PATRICK R	LANCASTER
FEERO, W GREGORY	STUDENT
FEES JR, MD, ARCH W	BLAIR
FEGLEY, DO, JANIS E	WASHINGTON
FEHNEL, MD, STEPHEN H	BERKS
FEHRLE, MD, WILFRID M	STUDENT
FEICHT, DO, CHARLES M	BEAVER
FEICK, MD, RALPH H	BERKS
FEIFER, RICHARD A	STUDENT
FEIG, MD, STEPHEN A	PHILADELPHIA
FEIGL, FRANCES M	STUDENT
FEIN, MD, DEBORAH L	ALLEGHENY
FEIN, DO, HOWARD K	MONTGOMERY
FEINBERG, CURT M	STUDENT
FEINBERG, MD, DAVID H	NORTHAMPTON
FEINBERG, MD, KALMEN A	SCHUYLKILL
FEINBERG, MARK W	STUDENT
FEINBERG, MD, STANFORD S	BERKS
FEINER, MD, LAUREL A	MONTGOMERY
FEINER, DO, STEVEN D	ALLEGHENY
FEINGOLD, MD, JOSEPH L	DELAWARE
FEINSMITH, MD, NORMAN	PHILADELPHIA
FEINSTEIN, MD, ALEX	LANCASTER
FEINSTEIN, MD, PETER A	LUZERNE
FEINSTEIN, MD, THEODORE A	PHILADELPHIA
FEIST, MD, JOHN H	ALLEGHENY
FEITL, MD, MARIANNE E	MONTOUR
FELDER, MD, HERMAN	ALLEGHENY
FELDMAN, MD, ARTHUR M	PHILADELPHIA
FELDMAN, MD, ELLA S	PHILADELPHIA
FELDMAN, MD, ELLEN K	MONTGOMERY
FELDMAN, MD, JULIAN D	PHILADELPHIA
FELDMAN, MD, MICHAEL S	NORTHAMPTON
FELDMAN, MD, NATHAN I	LACKAWANNA
FELDMAN, DO, NEIL H	LEHIGH
FELDMAN, MD, ROBERT A	PHILADELPHIA
FELDMAN, ROBERT P	STUDENT
FELDMAN, DO, SHARON L	ALLEGHENY
FELDMAN, MD, SHERRIE B	DAUPHIN
FELDMAN, MD, STEWART L	ALLEGHENY
FELDMEIER, MD, CURTIS J	BEAVER
FELGAR, RAYMOND E	STUDENT
FELICE, MD, CIVIE D	ALLEGHENY
FELINS, MD, KELLY J	LACKAWANNA
FELINS, MD, RAYMOND J	LACKAWANNA
FELIX, MD, DIONISIO	PHILADELPHIA
FELL, BRADLEY A	STUDENT
FELLERMAN, MD, HERBERT	LUZERNE
FELLIN, MD, CHRIS W	MONTOUR
FELLIN, MD, DENISE M	DAUPHIN
FELLIN, MD, RUDOLPH S	LUZERNE
FELSHER, MD, JONATHAN C	DELAWARE
FELTWELL JR, MD, PETER M	ALLEGHENY
FENCEL, MD, RICHARD M	DAUPHIN
FENELLO, MD, ANTHONY P	BLAIR
FENLIN JR, MD, JOHN M	PHILADELPHIA
FENN, MD, PATRICIA A	MONTGOMERY
FENNER, MD, HENRY E	LAWRENCE
FENSTEMACHER, MD, PAMELA A	MONTGOMERY
FENSTER, MD, MARTIN M	PHILADELPHIA
FEO, MD, LOUIS G	PHILADELPHIA
FERANCHAK, ANDREW P	STUDENT
FERENZI, MD, JAMES C	BRADFORD
FERGUSON, ANDREW S	STUDENT
FERGUSON, MD, DONALD G	ALLEGHENY
FERGUSON, MD, GARY M	ALLEGHENY
FERGUSON, MONICA O	STUDENT
FERGUSON, MD, ROBERT H	WESTMORELAND
FERGUSON, MD, ROGER J	ALLEGHENY
FERGUSON, MD, THOMAS G	ALLEGHENY
FERGUSON JR, MD, ALBERT B	ALLEGHENY
FERGUSON JR, MD, GUERRANT H	PHILADELPHIA
FERGUSON JR, MD, THEODORE J	ALLEGHENY
FERLAN, MD, LAWRENCE	ALLEGHENY
FERNANDES, MD, KARL S	ALLEGHENY
FERNANDEZ, MD, EDUARDO I	LYCOMING
FERNANDEZ, MD, JAVIER	PHILADELPHIA
FERNANDEZ, MD, JOSE R	MIFFLIN/JUNI
FERNANDEZ, MD, OSCAR V	ERIE
FERNANDO, MD, NEVILLE A	ERIE
FEROUZ, MD, ALIYA S	PHILADELPHIA
FEROUZ, MD, FAZEELA	PHILADELPHIA
FERRARA, MD, JOSEPH D	BUCKS
FERRARA, MD, LEONARD P	LEBANON
FERRARA, MD, VINCENT L	PHILADELPHIA
FERRARI, MD, VICTOR A	PHILADELPHIA
FERRARO, MD, FRANCIS T	ALLEGHENY
FERRARO, MD, MICHAEL M	LUZERNE
FERRARO, MD, PATRICK J	LACKAWANNA
FERRARO, MD, ROBERT J	ERIE
FERRENTINO, MD, FRANK L	YORK
FERRETTI, DO, SILVIA M	ERIE
FERRI, MD, HENRY G	ALLEGHENY
FERRIE, MD, PATRICIA M	PHILADELPHIA
FERRIER, MD, MELVIN C	CENTRE
FERRIGNO JR, MD, C JAMES	COLUMBIA
FERRIS, MD, GLENN A	CENTRE
FERRIS, MD, JOSEPH M	ERIE
FERRY, MD, GERALD W	BERKS
FERRY, MD, JANE A	BUCKS
FERRY, MD, NICHOLAS J	BUCKS

FESNIAK, MD, HENRY F MONTOUR
FESSLER, MD, THOMAS J ERIE
FETCHKO, MD, ALEXANDER M ALLEGHENY
FETTERMAN, MD, HENRY H LEHIGH
FETTEROLF, MD, DONALD E ALLEGHENY
FETTEROLF, MD, MICHAEL L VENANGO
FETZER, MD, ARTHUR E LEHIGH
FEUDALE, MD, RICHARD F SCHUYLKILL
FEUDO, MD, JULIA M LACKAWANNA
FEUDTNER, JOHN C STUDENT
FEUSSNER, MD, JAMES W PHILADELPHIA
FEY, GREGORY C STUDENT
FIALKOFF, MD, HENIE PHILADELPHIA
FICKE, MD, J RONALD PHILADELPHIA
FIDELER, MD, RICHARD DAUPHIN
FIDLER, SUZANNE A STUDENT
FIEDLER, MD, ERIC P ALLEGHENY
FIEDLER, MD, JAMES J PHILADELPHIA
FIEDLER, MD, ROY W ALLEGHENY
FIEHLER, MD, PAUL C ALLEGHENY
FIELD, MD, HOWARD L PHILADELPHIA
FIELD II, WILLIAM E STUDENT
FIELD MUNVES, MD, ELLEN M LEHIGH
FIELDS, MD, DAVID R LUZERNE
FIELDS, MD, RONALD H BUCKS
FIERER, MD, ROBERT R DAUPHIN
FIERRO, DO, VINCENT S ERIE
FIERSTEIN, MD, JEFFREY S PHILADELPHIA
FIGLIN, DO, JOSHUA M CENTRE
FIGUEROA, MD, WILLIAM G PHILADELPHIA
FIGUEROA, MD, YVETTE ALLEGHENY
FIGURA, MD, JUDITH H ALLEGHENY
FILE, MD, JAMES C MERCER
FILICKO, MD, JOANNE E STUDENT
FILIP, MD, JOHN R MONTGOMERY
FILIPEK, MD, STEELE W ALLEGHENY
FILIPEK, MD, WALTER J NORTHAMPTON
FILIPOWICZ, MD, THOMAS A BUCKS
FILIPPI, MD, RONALD S ERIE
FILIPPONE, MD, EDWARD J PHILADELPHIA
FILKINS, MD, KAREN ALLEGHENY
FILLMAN, MD, JOHN B HUNTINGDON
FILMYER JR, MD, EDWARD A PHILADELPHIA
FILOSA, MD, ROBERT J MONTGOMERY
FINCH, MD, ALBERTA M MONROE
FINDER, MD, MARC J BEDFORD
FINE, MD, ARTHUR P ALLEGHENY
FINE, MD, DANIEL ALLEGHENY
FINE, MD, ERIC W PHILADELPHIA
FINE, MD, JAMES R BRADFORD
FINEBERG, MD, CHARLES PHILADELPHIA
FINEGOLD, MD, AARON N ALLEGHENY
FINEGOLD, MD, JOSEPH ALLEGHENY
FINEGOLD, MD, RICHARD A ALLEGHENY
FINEGOLD, MD, WILFRED J ALLEGHENY
FINEMAN, MD, DEBORA S PHILADELPHIA
FINESTONE, MD, ALBERT J PHILADELPHIA
FINESTONE, MD, ISRAEL PHILADELPHIA
FINESTONE, MD, STEPHEN C ALLEGHENY
FINGERET, MD, ARNOLD E ALLEGHENY
FINGERUT, MD, JERALD C MONTGOMERY
FINGO, MD, ALBERT J MONTGOMERY
FINIKIOTIS, MD, MICHAEL W ALLEGHENY
FINK, MD, GORDON BERNARD PHILADELPHIA
FINK, MD, GREGORY W STUDENT
FINK, MD, JACK W MONTGOMERY
FINK, MD, PAUL J PHILADELPHIA
FINK JR, MD, ALBERT H DELAWARE
FINK JR, MD, HOWARD E DAUPHIN
FINKELSTEIN, MD, DAVID PHILADELPHIA
FINKELSTEIN, MD, GARY S BUCKS
FINKELSTEIN, MD, JORDAN W CENTRE
FINKELSTEIN, DO, LEONARD H MONTGOMERY
FINKELSTON, MD, THOMAS J STUDENT
FINKENSTADT, MD, ERIC V PHILADELPHIA
FINLEY, MD, JOHN G BUCKS
FINN, DANIEL T STUDENT
FINN, MD, DAVID R LYCOMING
FINN, MD, DORON H WASHINGTON
FINN, MD, JOANNE ERIE
FINN, MD, JOSEPH L PHILADELPHIA
FINN, DO, KATHLEEN M MONTOUR
FINN, MD, MARTHA J S LYCOMING
FINNEGAN, MD, WALTER J LEHIGH
FINO, MD, GREGORY LUZERNE
FINO, MD, JULIUS A WARREN
FIOL-SILVA, MD, ZORAIDA M PHILADELPHIA
FIORELLI, DO, ROBERT L LUZERNE
FIORICA, MD, VINCENT M CAMBRIA
FIORINI, MD, CYNTHIA M ALLEGHENY
FIRPO JR, MD, JOHN J DELAWARE
FIRST, MD, HOWARD E PHILADELPHIA
FIRST, MD, STEWART E PHILADELPHIA
FISCH, MD, JOHN M ALLEGHENY
FISCHBEIN, MD, RICHARD E LUZERNE
FISCHER, MD, DAVID H PHILADELPHIA
FISCHER, MD, EDWARD C BERKS
FISCHER, MD, H KEITH PHILADELPHIA
FISCHER, MICHELLE A STUDENT
FISCHER, MD, SHARON P PHILADELPHIA
FISCHER, MD, STEVEN W DELAWARE
FISCHER JR, MD, CARL R PHILADELPHIA
FISCHETTI, MD, JOHN L CHESTER
FISCHL, MD, EDWIN C ALLEGHENY
FISH, MD, JAMES E PHILADELPHIA
FISH, MD, LARRY A ALLEGHENY
FISHER, MD, ALVIN H MONTGOMERY
FISHER, DO, CLAUDIA C BERKS
FISHER, MD, CURTIS K ALLEGHENY
FISHER, MD, DON L ALLEGHENY
FISHER, MD, GAIL ALLEGHENY
FISHER, DO, GARY A PHILADELPHIA
FISHER, MD, HAROLD YORK
FISHER, MD, JAY B NORTHAMPTON
FISHER, MD, JOANNA M PHILADELPHIA
FISHER, MD, JOHN T CENTRE
FISHER, MD, JOSEPH S PHILADELPHIA
FISHER, MD, LUTHER I NORTHAMPTON
FISHER, MD, MARY S PHILADELPHIA
FISHER, MD, NORMAN J MONTGOMERY
FISHER, MD, PHILIP C BRADFORD
FISHER, ROBERT J STUDENT
FISHER, MD, ROBERT M MONTGOMERY
FISHER, MD, ROBERT S PHILADELPHIA
FISHER, MD, SARAH M PHILADELPHIA
FISHER, DO, SCOTT A PHILADELPHIA
FISHER, MD, SCOTT R ALLEGHENY
FISHER, MD, SETH M PHILADELPHIA
FISHER, MD, SETH W LUZERNE
FISHER, TODD M STUDENT
FISHER, MD, TODD R DAUPHIN
FISHER, DO, WILLIAM PHILADELPHIA
FISHER III, MD, GEORGE R PHILADELPHIA
FISHER JR, MD, JOSEPH W NORTHAMPTON
FISHKIN, MD, HYMEL ALLEGHENY
FISHMAN, DO, MORRIS A PHILADELPHIA
FISHMAN, DO, ROBERT F PHILADELPHIA
FISK, MD, DAVID E MONTOUR
FISSEL, BRETT S STUDENT
FISSEL, MD, GEORGE E LYCOMING
FISTER, MD, FREDERICK D LEHIGH
FITTING JR, MD, GEORGE M ALLEGHENY
FITZ, MD, RALPH W ALLEGHENY
FITZGERALD, MD, JAMES L LEHIGH
FITZGERALD, DO, JOHN J MONTGOMERY
FITZGERALD, MD, RICHARD P DAUPHIN
FITZMAURICE, MD, JOHN W DELAWARE
FITZPATRICK, DO, JAMES W SCHUYLKILL
FITZPATRICK, MD, JANE M PHILADELPHIA
FITZPATRICK, MD, LUCRETIA A DELAWARE
FITZPATRICK, MD, MARCIA A DELAWARE
FITZPATRICK, MD, RUTHANN P DELAWARE
FITZPATRICK, MD, THOMAS M MONTGOMERY
FITZSIMMONS, MD, AMY S DELAWARE
FITZSIMONS, MD, THOMAS R LEHIGH
FIUME, MD, THOMAS J LACKAWANNA
FLACCAVENTO, MD, FREDERICK G YORK
FLACCO, MD, ALBERT J BUCKS
FLAGG, MD, ALICE W PHILADELPHIA
FLAGG, STEPHANIE D STUDENT
FLAHERTY, MD, MORGAN F ALLEGHENY
FLAMBERG, MD, IRA W MERCER
FLAMINI, MD, JOHN A ERIE
FLAMM, MD, EUGENE S PHILADELPHIA
FLANAGAN, DO, EDWIN B DELAWARE
FLANAGAN, MD, H FRANKLIN PHILADELPHIA
FLANAGAN, MD, JOSEPH C DELAWARE
FLANAGAN, MD, MARGARET M FRANKLIN
FLANAGAN, MD, MICHAEL J MONTGOMERY
FLANAGAN, MD, MICHAEL P LUZERNE
FLANIGAN, MD, ROBERT E ALLEGHENY
FLANIGAN JR, MD, JOHN L CARBON
FLANNAGAN, MD, SAMUEL W WESTMORELAND
FLANNERY, MD, WILBUR E LAWRENCE
FLASHNER, MD, STEVEN C BUCKS
FLAUGH, DO, NANCY D F MONROE
FLEAGLE, MD, GENEVRA S CENTRE
FLEAGLE, MD, SAMUEL B CENTRE
FLECK, MD, LAURA B ALLEGHENY
FLEEGLER, MD, FRANCENE M PHILADELPHIA
FLEEGLER, MD, SAUL M WESTMORELAND
FLEEKOP, MD, PHILIP D MONTGOMERY
FLEISCHER, MD, ALAN N BERKS
FLEISCHER, MD, LEROY B DELAWARE
FLEISCHER, MD, LESLIE R LANCASTER
FLEISCHHACKER, DO, WAYNE PHILADELPHIA
FLEISHER, DO, RICHARD D PHILADELPHIA
FLEISHMAN, MD, MARTIN J MIFFLIN/JUNI
FLEMING, MD, ARTHUR W ALLEGHENY
FLEMING, MD, BURTON A PHILADELPHIA
FLEMING, MD, KENNETH D MONTGOMERY
FLEMMER, MD, MARK C BRADFORD
FLEMMING, MD, MATTHEW A PHILADELPHIA
FLETCHER, MD, ROBERT H PHILADELPHIA
FLETCHER, MD, SUZANNE W PHILADELPHIA
FLETCHER, MD, THOMAS F DAUPHIN
FLETMAN, DO, HERBERT PHILADELPHIA
FLICK, MD, KATHRYN L ERIE
FLICKINGER, MD, FREDERICK W ADAMS
FLICKINGER, MD, JOHN C ALLEGHENY
FLINT, MD, ERIC W ALLEGHENY
FLIT, MD, FRANK J ALLEGHENY
FLITTER, MD, MARC A ERIE
FLOM, MD, DAVID M ALLEGHENY
FLOM, MD, LYNDA L ALLEGHENY
FLOOD, MD, JAMES M BRADFORD
FLOOD, MD, KATHERINE M ALLEGHENY
FLOOD, MD, MICHAEL S LANCASTER
FLORA, MD, WILLIAM K CAMBRIA
FLOREK, MD, FLORIAN F ERIE
FLORENCE, MD, DAVID W DAUPHIN
FLORENTIN, MD, HERIBERTO M WESTMORELAND
FLORES, MD, ALBERTO C LANCASTER
FLORES, MD, CARLOS PHILADELPHIA
FLORES, MD, CARLOS I LAWRENCE
FLORES, MD, EVELYN R BERKS
FLORES, MD, MARIA L DELAWARE
FLORES, MD, MAY R FAYETTE
FLORES JR, MD, EMILIO G ELK/CAMERON
FLORIAN, MD, FREDERICK M ALLEGHENY
FLORIO, RICHARD M STUDENT
FLOURAS, MD, KATHY MONTOUR
FLOWERS, MD, PETER B LEBANON
FLOYD, MD, SUSAN L ALLEGHENY
FLURKEY, MD, EMERSON C DAUPHIN
FLYNN, MD, J DENNIS BLAIR
FLYNN, MD, RICHARD J BRADFORD
FLYNN-RODDEN, MD, KARIN PHILADELPHIA
FOBIA, MD, JOHN B PHILADELPHIA
FOCHLER, MD, FRANCIS J BLAIR
FOCHT, CHERYL A STUDENT
FODERARO, MD, ANTHONY E BUCKS
FODERARO, MD, JOHN C PHILADELPHIA
FOGEL, MD, STEWART R ALLEGHENY
FOGLEY, MD, ANEES R LACKAWANNA
FOKSTUEN, MD, TERJE S MCKEAN
FOLANDER, MD, HAL L NORTHAMPTON
FOLB, MD, HENRY A ALLEGHENY
FOLDES, MD, JULIUS LUZERNE
FOLDES, MD, PETER J PHILADELPHIA
FOLDES, MD, STEVEN I MONTOUR
FOLDES-ROTH, MD, ELISABETH BERKS
FOLEY, CHRISTOPHER A STUDENT
FOLEY, MD, EDWARD C ALLEGHENY
FOLEY, MD, T RAYMOND LANCASTER
FOLEY JR, MD, EDWARD L WASHINGTON
FOLK, MD, JEFFREY R LUZERNE
FOLK, DO, MARK E LEBANON
FOLLWEILER, MD, BARRY R LEHIGH
FOLTZ, EXEC SEC, SUSAN LEBANON
FONDROFF, MD, DAVID L ALLEGHENY
FONG, MD, JAKE WESTMORELAND
FONG, MD, JOHN K ALLEGHENY
FONSECA, DO, MANUEL A LUZERNE
FONTANA, MD, ARMAND L ALLEGHENY
FONTANA, MD, FRANK L ALLEGHENY
FOOR, MD, JEFFREY L BEDFORD
FOOTERMAN, MD, HAROLD ALLEGHENY
FORAUER, MD, ANDREW R DAUPHIN
FORBES, MD, J DEXTER ALLEGHENY
FORBES, MD, THOMAS W ALLEGHENY
FORCE, MD, THOMAS B PHILADELPHIA
FORCEY, MD, LLOYD R LYCOMING
FORCINA JR, MARIO L STUDENT
FORD, MD, D PATRICK PHILADELPHIA
FORD, MD, FRANCIS W BUCKS
FORD, MD, ROBERT W ALLEGHENY
FORD, MD, WILLIAM B ALLEGHENY
FORD, MD, WILLIAM T LYCOMING
FOREMAN, MD, BRUCE P ERIE
FOREST, MD, JEAN L PHILADELPHIA
FORGIONE JR, MICHAEL A STUDENT
FORKER, MD, THOMAS LEBANON
FORKER, MD, THOMAS S LYCOMING
FORMAN, MD, BRUCE H CHESTER
FORMAN, MD, HARVEY R PHILADELPHIA
FORMAN, MD, IRWIN H LANCASTER
FORMAN, MD, JOSEPH E PHILADELPHIA
FORMAN, MD, KENNETH J PHILADELPHIA
FORMAN, MD, STEVEN D ALLEGHENY
FORMAN, MD, STEVEN T PHILADELPHIA
FORMANEK, MD, GREGORY A BLAIR
FORNASIER, MD, LOUIS S DELAWARE
FORNWALT, MD, GEORGE R DELAWARE
FORNWALT, MD, HELEN L PHILADELPHIA
FORREST, MD, LEONARD E ERIE
FORRY, EXEC SEC, CANDY MONROE
FORSTATER, MD, ALAN T PHILADELPHIA
FORSTER, DO, CARL J SCHUYLKILL
FORSTER, MD, TERRENCE J BUCKS
FORSYTHE, AMY E STUDENT
FORSYTHE, DANNY W STUDENT
FORSYTHE, MD, PATRICK D B DAUPHIN
FORTI, MD, WILLIAM P DAUPHIN
FORTIER, MD, GREGORY A YORK
FORTUNATO, MD, JAMES J ALLEGHENY
FOSS, MD, DAVID E ALLEGHENY
FOSTER, MD, EDWIN N YORK
FOSTER, MD, FRANK B PHILADELPHIA
FOSTER, MD, HOWARD K ALLEGHENY
FOSTER, MD, IAN S MONROE
FOSTER, MD, JILL A PHILADELPHIA
FOSTER, MD, JOHN S CHESTER
FOSTER, MD, MARK R ALLEGHENY
FOSTER, MD, RICHARD B BRADFORD
FOSTER, MD, RICHARD G ALLEGHENY
FOSTER, MD, SCOTT A MONTGOMERY
FOSTER, MD, SYLVIA L MONTGOMERY
FOSTER, MD, WALTER D WESTMORELAND
FOSTER JR, MD, FREDERICK G BUTLER
FOSTER JR, MD, JOHN V DAUPHIN
FOSTER-DRAIN, MD, ROBIN L PHILADELPHIA
FOULK JR, MD, MORRIS DELAWARE
FOULSHAM II, MD, CHARLES K CLINTON
FOURNIER, MD, RAYMOND LACKAWANNA
FOUST, MD, TILMAN H DAUPHIN
FOUST, MD, WILSON A LANCASTER
FOWBLE, MD, BARBARA PHILADELPHIA
FOWLER, MD, DAVID P ALLEGHENY
FOWLER, MD, ERIC K LANCASTER
FOWLER, MD, PAUL B PHILADELPHIA
FOWLER, SANDRA M STUDENT
FOWLER, MD, WYATT C MONTGOMERY
FOX, COLEEN L STUDENT
FOX, MD, CRAIG D WASHINGTON
FOX, MD, DONALD C BUTLER
FOX, MD, MICHAEL L MONTGOMERY
FOX, MD, ROBERT D PHILADELPHIA
FOX, MD, ROGER E DELAWARE
FOX, MD, STEPHEN C CHESTER
FOX, MD, WILLIAM F LEHIGH
FOX IV, MD, JAMES W PHILADELPHIA
FOXX, MD, WILLIAM F CHESTER
FRABLE, MD, DEAN G SCHUYLKILL
FRAC, MD, MICHAEL J ALLEGHENY
FRAGOLA, MD, JORGE A ALLEGHENY
FRAILEY, DO, GREGORY R BRADFORD
FRAKES, MD, SHIRLEY I PHILADELPHIA
FRALEY, MD, EDITH L ALLEGHENY
FRALEY, MD, HENRY W ARMSTRONG
FRAME, MD, DAVID C WASHINGTON
FRANCE, MD, LAURENCE W LANCASTER
FRANCE, MD, ROBERT O LYCOMING
FRANCESCANGELI JR, MD, VINCENT MONROE
FRANCIS, MD, GEORGE J ALLEGHENY
FRANCIS, MD, LEON R LUZERNE
FRANCIS, MD, PAUL D MONTOUR
FRANCO, MD, ALEXANDER CENTRE
FRANCO, MD, FRANK A BERKS
FRANCOIS, MD, MAX B BERKS
FRANCOS, MD, CHARLES G LANCASTER
FRANCZYK, DARREN A STUDENT
FRANGOS, MD, JAMES N LACKAWANNA
FRANK, MD, BARBARA B DELAWARE
FRANK, MD, EVAN D PHILADELPHIA
FRANK, MD, HERBERT L DAUPHIN
FRANK, MD, JEFFREY B BERKS
FRANK, MD, LEONARD A MONTGOMERY
FRANK, MD, MARTIN N MONTGOMERY
FRANK, DO, MELANIE PHILADELPHIA
FRANK, MD, PAUL E MONTGOMERY
FRANK, MD, ROBERT L MONTGOMERY
FRANK, DO, RONALD B MONTGOMERY
FRANK, MD, TOBY L STUDENT
FRANK, MD, WILLIAM O PHILADELPHIA
FRANKE, MD, FREDERICK R ALLEGHENY
FRANKEL, MD, ARTHUR M MONTGOMERY
FRANKEL, MD, CARL A DAUPHIN
FRANKEL, MD, HARRY A PHILADELPHIA
FRANKEL, MD, LEON A PHILADELPHIA
FRANKEL, MD, LESLIE B MONTGOMERY
FRANKEL, MD, MATTHEW C PHILADELPHIA
FRANKEL, MD, ROBYN F PHILADELPHIA
FRANKEL, MD, SHARON R DAUPHIN
FRANKEL, MD, VICTOR R PHILADELPHIA
FRANKENFIELD, MD, BRUCE A LEHIGH
FRANKENSTEIN, MD, HERBERT ALLEGHENY
FRANKENY II, MD, JOHN R DAUPHIN
FRANKL, MD, WILLIAM S PHILADELPHIA
FRANKLIN, MD, DAVID P MONTOUR
FRANKLIN, MD, IRVIN D BUCKS
FRANKLIN, MD, JOHN W B ALLEGHENY
FRANKLIN, MD, NORMAN ERIE
FRANKOVITCH, MD, KARL F ERIE
FRANTZ, MD, ALFRED S FRANKLIN
FRANTZ, MD, LINDA S LACKAWANNA
FRANTZ, MD, ROBERT C BERKS
FRANTZ, MD, ROBERT R CARBON
FRANZ, MD, JOHN P ALLEGHENY
FRANZ, DO, MARK G FAYETTE
FRANZ, MD, PAMELA J PHILADELPHIA
FRANZ, MD, THOMAS A ALLEGHENY
FRASER III, MD, HUGH E MONTOUR
FRATTALI, MD, AUGUST LACKAWANNA
FRAUNFELDER, MD, JOHN A NORTHAMPTON
FRAYER, MD, WILLIAM C PHILADELPHIA
FRAZIER, MD, THOMAS G MONTGOMERY
FRAZIER II, MD, JOHN E ALLEGHENY
FREDANE, MD, LEWIS M PHILADELPHIA
FREDERIC, MD, MYRON W PHILADELPHIA
FREDERICK, MD, PAUL L ARMSTRONG
FREDERICKS, MD, LILLIAN E PHILADELPHIA
FREDERICKSON, MD, HOWARD N YORK
FREDRICKSON, MD, VICTOR J BUCKS
FREEBERG, MD, JOHN R MONTGOMERY
FREED, MD, CLARENCE L BUCKS
FREED, MD, MARTIN I PHILADELPHIA
FREEDBERG, MD, LAWRENCE E WESTMORELAND
FREEDMAN, MD, ABRAHAM G PHILADELPHIA
FREEDMAN, MD, ALLAN P PHILADELPHIA
FREEDMAN, MD, DONALD B DAUPHIN
FREEDMAN, MD, E FANNIE PHILADELPHIA
FREEDMAN, MD, JACOB J PHILADELPHIA
FREEDMAN, MD, LAWRENCE T MONTGOMERY
FREEDMAN, MD, LOUIS J LUZERNE
FREEDMAN, DO, MITCHELL K PHILADELPHIA
FREEDMAN, DO, SUSAN R CENTRE
FREELAND, MD, GEORGE R DELAWARE
FREEMAN, MD, ALBERT W FRANKLIN
FREEMAN, MD, DANIAL M A MONTGOMERY
FREEMAN, MD, NANCYANNE PHILADELPHIA
FREEMAN, MD, RICHARD E POTTER
FREEMAN, MD, WILLIAM A FRANKLIN
FREENOCK JR, MD, THOMAS F DELAWARE
FREER, MD, CAROL V YORK
FREESE, MD, ANDREW DELAWARE
FREI, KAREN P STUDENT
FREID, MD, JEFFREY D PHILADELPHIA
FREIFELD, MD, MARTIN L LUZERNE
FREIMAN, MD, DAVID B PHILADELPHIA
FREIMUTH, MD, ERICH J MONTGOMERY
FREISTAT, MD, ERIC T DAUPHIN
FREIWALD, MD, MILTON J PHILADELPHIA
FREMER, MD, ABRAHAM PHILADELPHIA
FREMPONG-BOADU, ANTHONY K STUDENT
FRENCH, MD, ELIZABETH G CHESTER
FRENCH, MD, GORDON N CHESTER
FRENCH, SAMUEL W STUDENT
FRENCH, MD, TRAVIS A LAWRENCE
FRENCH, MD, WILLIAM M UNION
FRESHMAN, MD, JOHN R DAUPHIN
FRESOLI, MD, ROCCO P CHESTER
FREUDENBERG, MD, DORIS T MONTGOMERY

FREY, MD, JACQUELINE M	YORK
FREY, MD, JEFFREY A	YORK
FREYNIK, MD, JOSEPH G	LYCOMING
FRIBERG, MD, THOMAS R	ALLEGHENY
FRICCHIONE, MD, PATRICK J	LACKAWANNA
FRICK JR, EDWARD J	STUDENT
FRIDAY, MD, DANIEL M	BLAIR
FRIDAY, MD, JOHN R	ALLEGHENY
FRIDAY, MD, RUPERT H	ALLEGHENY
FRIDAY JR, MD, GILBERT A	ALLEGHENY
FRIED, DO, GORDON W	MONROE
FRIED, MD, GUY W	PHILADELPHIA
FRIED, MD, JEFFREY A	INDIANA
FRIED, MD, MARTIN B	LUZERNE
FRIED, MD, ROBERT C	CHESTER
FRIEDBERG, MD, ANDREA L	MONTGOMERY
FRIEDBERG, MD, JAY G	BUCKS
FRIEDBERG, MD, MILTON J	LEHIGH
FRIEDENBERG, MD, STEVEN B	NORTHAMPTON
FRIEDENBERG, MD, ZACHARY B	PHILADELPHIA
FRIEDLANDER, MD, MARK S	YORK
FRIEDLANDER, MD, MILTON A	DAUPHIN
FRIEDLANDER, MD, MYRON	ALLEGHENY
FRIEDLANDER, MD, STEVEN M	STUDENT
FRIEDMAN, MD, ABRAHAM W	ALLEGHENY
FRIEDMAN, MD, ADELE K	PHILADELPHIA
FRIEDMAN, MD, ALAN LEE	PHILADELPHIA
FRIEDMAN, MD, BART J	WESTMORELAND
FRIEDMAN, MD, BEN-ZION	DELAWARE
FRIEDMAN, MD, CARL J	CHESTER
FRIEDMAN, DO, DAVID S	MONTGOMERY
FRIEDMAN, MD, DEBRA L	PHILADELPHIA
FRIEDMAN, MD, DONALD	DELAWARE
FRIEDMAN, MD, ELLIS F	BERKS
FRIEDMAN, MD, EMILY D	PHILADELPHIA
FRIEDMAN, MD, ERIC S	ALLEGHENY
FRIEDMAN, MD, GAYLE F	PHILADELPHIA
FRIEDMAN, MD, HENRY B	LUZERNE
FRIEDMAN, MD, IRWIN	BUCKS
FRIEDMAN, MD, JEFFREY	PHILADELPHIA
FRIEDMAN, MD, JERALD N	NORTHAMPTON
FRIEDMAN, MD, LAWRENCE S	PHILADELPHIA
FRIEDMAN, MD, LORNA	PHILADELPHIA
FRIEDMAN, MD, MARK C	DAUPHIN
FRIEDMAN, DO, MARTIN L	PHILADELPHIA
FRIEDMAN, MD, PAUL A	MONTGOMERY
FRIEDMAN, MD, PAUL S	PHILADELPHIA
FRIEDMAN, MD, PHILLIP	BUCKS
FRIEDMAN, MD, RICHARD A	PHILADELPHIA
FRIEDMAN, MD, RONALD H	PHILADELPHIA
FRIEDMAN, MD, SIDNEY	PHILADELPHIA
FRIEDMAN, MD, SUMNER H	DAUPHIN
FRIEDRICH, MD, JOACHIM H	YORK
FRIEDRICH, MD, ROLAND	YORK
FRIEDRICH, MD, TOMAS	YORK
FRIEDSAM, MD, PATRICIA L	WASHINGTON
FRIEL, MD, MARGARET A	PHILADELPHIA
FRIEMAN, MD, BARBARA G	PHILADELPHIA
FRIEND, MD, ARTHUR	LUZERNE
FRIES, MD, ELIZABETH A	ALLEGHENY
FRIES, MD, GENE T	LYCOMING
FRISCH, MD, MARK S	PHILADELPHIA
FRISCH, MD, SANDFORD C	LANCASTER
FRITCHEY JR, MD, JOHN A	DAUPHIN
FRITCHLEY, MD, RODNEY S	CUMBERLAND
FRITER, MD, BARRY S	PHILADELPHIA
FRITZ, MD, KAREN I	PHILADELPHIA
FRITZ, MD, LOUISA J	WYOMING
FRITZ, MD, WILLIAM D	VENANGO
FRITZ, MD, WILLIAM T	BLAIR
FRITZ JR, MD, KARL J	WARREN
FRIZZI, JAMES D	STUDENT
FROBESE, MD, ALFRED S	PHILADELPHIA
FROEHLICH, MD, A DAVID	DAUPHIN
FROESCHLE, MD, JAMES E	MONROE
FROIX, ANTHONY J	STUDENT
FROMAN, MD, STEPHEN M	BEAVER
FROMME, MD, KENNETH L	DAUPHIN
FRONCZEK JR, MD, WILLIAM M	WASHINGTON
FRONDUTI, MD, LUCIAN J	WESTMORELAND
FRONDUTI, MD, ROBERT L	ALLEGHENY
FROOZAN, MD, HOMAYOON	LACKAWANNA
FROST, MD, ALBERT G	MONTGOMERY
FROST, MD, HOLLY A	ALLEGHENY
FROST, MD, STEPHEN S	PHILADELPHIA
FROST JR, MD, WILLIAM W	WASHINGTON
FRUMIN, MD, ABRAHAM M	PHILADELPHIA
FRUNCILLO, MD, RICHARD J	PHILADELPHIA
FRY, MD, CHLOE O	DAUPHIN
FRY, MD, ROBERT L	FRANKLIN
FRYCZYNSKI, MD, TADDEUS P	ERIE
FRYE, MD, JOHN W	LUZERNE
FRYE, DO, JOYCE	PHILADELPHIA
FRYE, MD, PAUL E	ALLEGHENY
FRYE, MD, VERYL F	CLINTON
FRYER, MD, THERESA F	ERIE
FU, MD, FREDDIE H	ALLEGHENY
FUCCI, MD, MICHAEL J	PHILADELPHIA
FUCHS, MD, PAUL D	ALLEGHENY
FUENTES, MD, MICHAEL A	ALLEGHENY
FUERST, MD, NICHOLAS E	WASHINGTON
FUGARO, DO, ANTHONY J	MONTGOMERY
FUGATE, MD, JAMES K	JEFFERSON
FUGATE, DO, JEFFREY S	DAUPHIN
FUGATE JR, MD, HOWARD	JEFFERSON
FUGE, MD, L H	ALLEGHENY
FUHRER, MD, RUSSELL S	ALLEGHENY
FUHRMAN, MD, CARL R	ALLEGHENY
FUJIMAGARI, MICHAEL M	STUDENT
FUJIMAGARI, MD, TAK	LAWRENCE
FUKUDA, WILLIAM P	STUDENT
FUKUI, MD, PAUL T	CHESTER
FULCHIERO, MD, GREGORY J	BLAIR
FULCINITI, MD, ROCCO A	ALLEGHENY
FULD, MD, ROBERT A	LEBANON
FULLER JR, MD, LONNIE E	PHILADELPHIA
FULTON, MD, WILLIAM O	YORK
FULTZ, MD, CRAIG W	DAUPHIN
FUNCH, MD, ROSS S	PHILADELPHIA
FUNG, MD, JOHN J	ALLEGHENY
FUNK JR, MD, ELMER H	PHILADELPHIA
FUNK JR, MD, F COLEMAN	LYCOMING
FUNKE, MD, ALVIN H	COLUMBIA
FUNKHOUSER, MD, GEORGE R	MONTOUR
FUNKHOUSER, MD, JAY L	BEAVER
FUNT, MD, LOREN	ALLEGHENY
FUOCO, MD, JOHN J	MIFFLIN/JUNI
FUREY, MD, SANDY A	LACKAWANNA
FUREY JR, MD, CHARLES A	PHILADELPHIA
FURGIUELE, MD, FRANCIS P	MONTGOMERY
FURGIUELE-IRACKI, MD, NATALIE	ALLEGHENY
FURIA, MD, FREDERICK A	DELAWARE
FURIA, MD, ROBERT	DELAWARE
FURIGAY, MD, R L	CAMBRIA
FURLONG, BRENDAN R	STUDENT
FURMAN, MD, DONALD J	WARREN
FURMAN, MD, HAROLD B	MONTGOMERY
FURMAN, MD, JOSEPH M R	ALLEGHENY
FURNARY, MD, ANTHONY P	ALLEGHENY
FURNARY, MD, JAMES S	CAMBRIA
FURNER, DO, CARL L	LUZERNE
FURR, MD, CHARLES M	ERIE
FURTADO, MD, FRANCISCO DE A	NORTHUMBERLAND
FURUKAWA, MD, SATOSHI	PHILADELPHIA
FUSCO, MD, FRANK	MONROE
FUSCO, MD, ROBERT D	ALLEGHENY
FUSCO-RIPKA, MD, GIOVANNA D	BERKS
FUSIA, MD, JOSEPH F	ALLEGHENY
FUSIA JR, MD, DONALD A	WESTMORELAND
FUST, MD, JOHN A	ERIE
FUTCHER, MD, PALMER H	PHILADELPHIA
FUTRELL, MD, J WILLIAM	ALLEGHENY
FYNES, MARGARET M	STUDENT

G

GAARY, MD, ALVIN E	DELAWARE
GABALA, MD, JOHN M	NORTHUMBERLAND
GABOS, MD, CHARLES W	ALLEGHENY
GABOS, MD, DENNIS K	ALLEGHENY
GABOS, MD, PAUL	ALLEGHENY
GABRIEL, MD, DANIEL E	WASHINGTON
GABRIEL, MD, LARRY C	LAWRENCE
GABRIEL, MD, LOUIS T	SCHUYLKILL
GABRIEL, MD, PETER	FAYETTE
GABRIEL, MD, STEVEN A	LAWRENCE
GABRIEL, MD, VERONICA	MONTGOMERY
GABRIELE, MD, AUGUST A	YORK
GABRIELE, MD, FREDERICK J	ALLEGHENY
GABRIELE, MD, PHILIP J	ALLEGHENY
GABROY, MD, ALLEN S	DELAWARE
GABUZDA, MD, THOMAS G	PHILADELPHIA
GADANI, MD, MANU R	CUMBERLAND
GADBOIS, MD, WILLIAM F	NORTHAMPTON
GAFFIELD, JAMES	STUDENT
GAFFNEY, MD, EDMUND J	MONTGOMERY
GAFFNEY, MD, MICHAEL B	ALLEGHENY
GAFFNEY, MD, PAUL C	ALLEGHENY
GAFFORD, MD, GRADY D	TIOGA
GAGIANAS, MD, PETER J	ALLEGHENY
GAHDHI, MD, SANJAY M	PHILADELPHIA
GAIA, MD, JUAN D	LUZERNE
GAIDYS, MD, WILLIAM G	BRADFORD
GAIN, MD, THOMAS S	PHILADELPHIA
GAINOR, MD, PATRICIA A	FAYETTE
GAISFORD, MD, JOHN C	ALLEGHENY
GAITHER, MD, HERBERT	DAUPHIN
GAJULA, MD, L NARAYAN	CARBON
GALANIS, MD, SOTIRE E	LANCASTER
GALANTE, MD, LISA	PHILADELPHIA
GALASSI JR, MD, JOSEPH W	LEHIGH
GALASSO, MD, GWENDOLYN M	LUZERNE
GALASSO III, DO, JAMES W	LUZERNE
GALATI, MD, VICTOR G	DELAWARE
GALBRAITH, DAVID W	STUDENT
GALDUN, MD, JOHN P	ALLEGHENY
GALENA IV, EDWARD C	STUDENT
GALGON, MD, JOHN P	LEHIGH
GALIB, MD, SAMUEL H	CHESTER
GALIETTA, MD, MARYANN C	BUCKS
GALLA, KATHY L	STUDENT
GALLAGER, MD, JAMES G	MONTOUR
GALLAGHER, MD, BRYAN J	DAUPHIN
GALLAGHER, MD, DORIS B	MONTGOMERY
GALLAGHER, MD, HENRY G	LUZERNE
GALLAGHER, MD, JOHN E	ARMSTRONG
GALLAGHER, DO, JOHN M	ERIE
GALLAGHER, MD, JOHN T	BUCKS
GALLAGHER, MD, JUDITH E	DAUPHIN
GALLAGHER, MD, MICHAEL D	YORK
GALLAGHER, MD, MICHAEL J	LACKAWANNA
GALLAGHER, MD, PHILIP E	ERIE
GALLAGHER-SHRIFT, MD, KATHERINE A	DAUPHIN
GALLEN, MD, JOHN H	BERKS
GALLETTA, MD, ANTHONY S	WASHINGTON
GALLI, MD, SHARON A	ALLEGHENY
GALLIA, MD, FRANCIS J	DAUPHIN
GALLIGAN, MD, WILLIAM J	PHILADELPHIA
GALOS, MD, RICHARD S	ALLEGHENY
GALPERIN, MD, ZHANNA V	PHILADELPHIA
GALTMAN, MD, LAWRENCE M	LEHIGH
GALUCKI, MD, SHIRLEY V	NORTHAMPTON
GAMBERINO, WILLIAM C	STUDENT
GAMBETTA, MD, ESMERALDA	PHILADELPHIA
GAMMON, RICHARD R	STUDENT
GANDHI, MD, ANANT J	ALLEGHENY
GANDHI, MD, HARSH	LUZERNE
GANDY, DO, DANIEL R	LYCOMING
GANGAROSA, MD, LISA M	PHILADELPHIA
GANGLOFF, MD, MICHAEL A	YORK
GANIBAN, MD, JUSTINIANO S	PHILADELPHIA
GANIME, MD, PETER D	MONTGOMERY
GANNON, MD, MICHAEL J	YORK
GANNON, MD, REYNALDO T	CAMBRIA
GANNON, MD, ROBERT P	ALLEGHENY
GANOTT, MD, MARIE A	ALLEGHENY
GANSMAN, MD, DAVID H	PHILADELPHIA
GANSNER, MD, ROBYN K	BERKS
GANTER, DO, GERARD C	PHILADELPHIA
GANTI, MD, MURTY S	ALLEGHENY
GARBAK, MD, FRANK	PHILADELPHIA
GARBARINO, MD, JOSEPH L	NORTHAMPTON
GARBER, MD, DONNA A	PHILADELPHIA
GARBER, MD, EDWARD H	YORK
GARBES, MD, ARCHIMEDES D	MONTOUR
GARCIA, MD, ALFREDO J	BUTLER
GARCIA, MD, ANTONIO S	BERKS
GARCIA, MD, CELSO R	PHILADELPHIA
GARCIA, MD, DIOSDADO A	ALLEGHENY
GARCIA, MD, DOMINADOR I	CHESTER
GARCIA, MD, DOMINGO A	FRANKLIN
GARCIA, MD, EMANUEL E	PHILADELPHIA
GARCIA, MD, GERALD D	ERIE
GARCIA, MD, GUILLERMO	DAUPHIN
GARCIA, MD, JOSE A	DAUPHIN
GARCIA, MD, JOSE R	LEHIGH
GARCIA, MD, LAUREANO P	PHILADELPHIA
GARCIA, MARIA M	STUDENT
GARCIA, MD, MARIAN	CENTRE
GARDEN, MD, JACK L	PHILADELPHIA
GARDEN, MD, MARC DAVID	PHILADELPHIA
GARDENER, MD, RALPH	ALLEGHENY
GARDNER, MD, ALAN M	CHESTER
GARDNER, DO, BONNIE J	PHILADELPHIA
GARDNER, MD, GEORGE E	YORK
GARDNER, MD, JOHN C	WYOMING
GARDNER, DO, MARSHALL K	PHILADELPHIA
GARDNER, MD, MORRIS Z	ALLEGHENY
GARDNER, MD, ROBERT S	ALLEGHENY
GARDNER, MD, SHYRELLE	PHILADELPHIA
GARDNER, MD, STUART A	LAWRENCE
GARDNER JR, MD, JAMES L	LAWRENCE
GARDNER SR, MD, JAMES L	LAWRENCE
GARDYABZ, MD, MIROSLAW D	DAUPHIN
GAREIS, MD, JOHN W	LANCASTER
GARES, MD, KATHIE ANN	PHILADELPHIA
GAREY, MD, HERMAN S	LACKAWANNA
GARFINKEL, MD, MARC E	ALLEGHENY
GARFINKLE, MD, WILLIAM B	PHILADELPHIA
GARG, MD, MONIKA	DAUPHIN
GARIBIAN, MD, GARO S	PHILADELPHIA
GARLAND, MD, JEFFREY L	ALLEGHENY
GARMAN, MD, RAY F	BRADFORD
GARNER, MD, BLAINE R	BUCKS
GARNER, MD, LOIS L	VENANGO
GARNER, MD, WILLIAM J	ALLEGHENY
GARNET, MD, JAMES D	PHILADELPHIA
GAROFALO, MD, CARL A	FAYETTE
GAROFOLA, MD, JOHN H	LANCASTER
GAROFOLI, MD, CAESAR A	ALLEGHENY
GARONE, MD, MARLENE	ALLEGHENY
GARRETT, MD, JEFFREY S	ALLEGHENY
GARRETT, MD, JOHN C	BRADFORD
GARRETT, MD, KEVIN O	ALLEGHENY
GARRETT, MD, PAUL R	BUCKS
GARRETT JR, MD, WILLIAM S	ALLEGHENY
GARRETTSON, MD, JAMES A	INDIANA
GARRIDO, MD, EDDY	LANCASTER
GARRIGAN, DO, DIANE M	NORTHAMPTON
GARRIOTT, MD, JOHN C	MERCER
GARROTT, MD, JOHN W	ARMSTRONG
GARRY, MD, LEONARD J	PHILADELPHIA
GARSON, MD, WARFIELD	WASHINGTON
GARTLAND, DO, CHARLES J A	DELAWARE
GARTLAND, MD, JOHN J	PHILADELPHIA
GARTNER, MD, WILLIAM S	DELAWARE
GARTNER JR, MD, WILLIAM S	DELAWARE
GARVER, MD, JAMES J	ALLEGHENY
GARVER, MD, KENNETH L	ALLEGHENY
GARVEY, MD, EDMUND P	LANCASTER
GARVEY, MD, WILLIAM P	ERIE
GARY, MD, GERALD L	PHILADELPHIA
GARY, MD, ROBERT J	LEHIGH
GASCON, MD, PERLA G	PHILADELPHIA
GASH, MD, ARNOLD K	PHILADELPHIA
GASH, MD, RICHARD M	PHILADELPHIA
GASKINS, MD, ALBERT L	PHILADELPHIA
GASOWSKI, MD, GARY L	YORK
GASPAR, MD, STEPHEN R	PHILADELPHIA
GASPAR, MD, VICTORIA S	PHILADELPHIA
GASPARI, MD, RAYMOND J	YORK
GASS, MD, JENNIFER S	PHILADELPHIA
GASTALDO, MD, JOHN A	LANCASTER
GASTINEAU, MD, ROBERT M	ALLEGHENY
GASTON, MD, NOREEM M	BUCKS
GASULL JR, MD, H ROBERT	PERRY
GATSKI, MD, ROBERT L	MONTOUR
GATTER, MD, ROBERT A	MONTGOMERY
GATTI, MD, DOMINIC L	MONTGOMERY
GATTI, MD, JOSEPH W	INDIANA
GATTUSO JR, MD, JOSEPH W	BLAIR
GAUDIO, MD, JOHN C	LUZERNE
GAUDIO JR, MD, RALPH	ALLEGHENY
GAUL, MD, JAMES J	BUCKS
GAUL, MD, LAWRENCE W	DAUPHIN
GAULIN, MD, J CLAUDE	NORTHAMPTON
GAULT, MD, JAMES H	LANCASTER
GAUNTNER, MD, WALLACE C	ALLEGHENY
GAUS, MD, VICTORIA M	ALLEGHENY
GAUSE, MD, PAUL E	LANCASTER
GAUSLING, MD, SHARON C	LEHIGH
GAUSS, MD, WILLIAM F	ALLEGHENY
GAVIN, MD, GEORGE M	WESTMORELAND
GAVIN, MD, LAURENCE J	PHILADELPHIA
GAVIN JR, MD, J ROBERT	LACKAWANNA
GAWCHIK, DO, SANDRA M	DELAWARE
GAWLAS, DO, MICHAEL R	DAUPHIN
GAY, MD, THOMAS C	ALLEGHENY
GAYDOS, MD, JOHN D	BEAVER
GAYDOS, MARIA A	STUDENT
GAYDOS, MD, THOMAS L	NORTHAMPTON
GAYLOR, MD, DONALD H	LEHIGH
GAYNER, MD, ROBERT S	NORTHAMPTON
GAYNOR, MD, WILLIAM S	LANCASTER
GAZDICK, MD, MARY ANNE	MONTGOMERY
GAZEK, MD, FRANCISCO A	LUZERNE
GAZOWSKI, MD, THOMAS E	LUZERNE
GEADAH, MD, FOUAD A	DAUPHIN
GEARHART, MD, LYSTER M	LEHIGH
GEE, MD, WILLIAM	LEHIGH
GEER, MD, FRANK D	LAWRENCE
GEETTER, MD, PHILIP H	BUCKS
GEGWICH, MD, FRANK	COLUMBIA
GEGWICH, MD, JOSEPH F	COLUMBIA
GEHL, MD, LEONARD G	ALLEGHENY
GEHL, MD, RICHARD S	ALLEGHENY
GEHMAN, MD, JOHN W	MIFFLIN/JUNI
GEHMAN, MD, M JACK	BERKS
GEHRING, MD, DAVID A	VENANGO
GEHRIS, MD, JAMES C	NORTHMBRLAND
GEHRIS, MD, LEROY A	BERKS
GEHRMANN, ROBIN M	STUDENT
GEHRON JR, MD, WILLIAM H	LYCOMING
GEIB, ELIZABETH H	STUDENT
GEIGER, MD, LEONARD R	MONTGOMERY
GEIGLE, MD, CARL F	ERIE
GEISE, DO, STEVEN W	CLINTON
GEISELMAN, MD, DOUGLAS L	YORK
GEIST, MD, AUDREY A	PHILADELPHIA
GELACEK, MD, PHILIP A	ARMSTRONG
GELB, MD, HOWARD J	PHILADELPHIA
GELB, MD, IRA D	PHILADELPHIA
GELBLUM, DAPHNA Y	STUDENT
GELEHRTER, MD, JOSEPH	PHILADELPHIA
GELET, MD, THEODORE R	ALLEGHENY
GELETKA, MD, SUSAN M	ALLEGHENY
GELFAND, MD, DAVID	PHILADELPHIA
GELFAND, MD, JONATHAN L	PHILADELPHIA
GELFAND, MD, STEVEN B	VENANGO
GELLER, MD, JOSEPH	PHILADELPHIA
GELLER, MD, MARK J	ALLEGHENY
GELLER, DO, ROBERT J	DELAWARE
GELMAN, MD, BETH P	PHILADELPHIA
GELMAN, MD, BRUCE P	PHILADELPHIA
GELMAN, KENNETH J	STUDENT
GELMAN, MD, RICARDO	PHILADELPHIA
GELMAN, MD, SCOTT F	PHILADELPHIA
GELMAN, STEVEN M	STUDENT
GELOVICH, STEPHEN P	STUDENT
GEMIL, MD, CORAZON G	CHESTER
GEMIL-CORRAL, MD, ANGELITA G	CHESTER
GEMMILL, MD, REGINALD B	YORK
GENATO, MD, JAIME M	WESTMORELAND
GENDELL, MD, HOWARD M	ALLEGHENY
GENDI, MD, WAGIH A S	ALLEGHENY
GENERALOVICH, MD, THOMAS	ALLEGHENY
GENERETTE, MD, WILLIAM O	ALLEGHENY
GENNARELLI, MD, THOMAS A	PHILADELPHIA
GENNARIA, MD, C REED	NORTHMBRLAND
GENNAULA, MD, CHARLES P	ALLEGHENY
GENOVESE, MD, FRANK N	ARMSTRONG
GENT, MD, DONALD H	YORK
GENTER, MD, BRUCE E	PHILADELPHIA
GENTILCORE, THOMAS B	STUDENT
GENTILE, MD, ANTHONY F	ALLEGHENY
GENTILE, MD, ANTHONY J	LACKAWANNA
GENTILEZZA, MD, KENNETH W	LACKAWANNA
GENTZLER II, MD, RICHARD D	LANCASTER
GEORGE, MD, ANDREW	CAMBRIA
GEORGE, MD, DAVID L	BERKS
GEORGE, MD, DOUGLAS T	ERIE
GEORGE, MD, GARY R	WASHINGTON
GEORGE, MD, JACOB	ERIE
GEORGE, MD, JAMES M	ALLEGHENY
GEORGE, MD, JOHN J	ALLEGHENY
GEORGE, MD, JOHN M	ALLEGHENY
GEORGE, MD, ROBERT A	ALLEGHENY
GEORGE, MD, ROBERT B	FRANKLIN
GEORGE, MD, ROBERT N	ALLEGHENY
GEORGE, MD, ROMANI S	PHILADELPHIA
GEORGE, TIMOTHY G	STUDENT
GEORGETSON, MD, MICHAEL J	BRADFORD
GEORGEVICH, MD, PHILIP G	ALLEGHENY
GEORGY, MD, FAROUK M	LYCOMING
GERACI, MD, GASPERE C	DAUPHIN
GERARD, MD, JOSEPH A	ALLEGHENY
GERBER, MD, HARRIS S	PHILADELPHIA
GERBER, DO, MELVIN D	LANCASTER
GERBER, MD, MICHAEL L	ALLEGHENY
GERBER, MD, PAUL	PHILADELPHIA
GERBER, MD, WALTER L	PHILADELPHIA
GERBERT, MD, KATHLEEN H	LANCASTER

GERCHMAN, MD, LEROY B	LEHIGH
GERDES, MD, JEFFREY S	PHILADELPHIA
GERGER, MD, JOSEPH P	WESTMORELAND
GERHARD, MD, WILHELM	DELAWARE
GERHART, MD, CLARK D	LEHIGH
GERHART, MD, GEORGE R	BERKS
GERHART, MD, GUY H	JEFFERSON
GERHART, MD, WILLIS C	MONTGOMERY
GERIG, MD, JOHN S	MONTOUR
GERLACH, MD, DETLEF H	YORK
GERLACH IV, MD, CHARLES D	DAUPHIN
GERMAN, MD, ANTONIO I	ERIE
GERMAN, MD, TERRY M	MONTGOMERY
GERNETH, MD, GEORGE J	ALLEGHENY
GERONIMO, MD, LAURO S	NORTHAMPTON
GERSHENSON, MD, STEPHEN R	MONTGOMERY
GERSHKOFF, MD, ARTHUR M	PHILADELPHIA
GERSON, MD, ANDREW G	MONTGOMERY
GERSON, MD, BENJAMIN	CHESTER
GERSON, MD, IRVIN M	CHESTER
GERSON, MD, JEFFREY R	ALLEGHENY
GERSTLEY III, MD, LOUIS	PHILADELPHIA
GERSTMAN, DO, ROBERT N	PHILADELPHIA
GESKEY, JOSEPH M	STUDENT
GESSNER, MD, THOMAS P	WESTMORELAND
GESSNER, MD, VICTORIA A	PHILADELPHIA
GETTE, MD, MICHAEL T	NORTHAMPTON
GETZ, MD, WILLIAM B	PHILADELPHIA
GEVAERT, MD, MICHAEL L	PHILADELPHIA
GEVIRTZ, MD, JEFFREY L	LEHIGH
GEVJAN, MD, ARMEN H	DELAWARE
GEYER, MD, DAVID W	BERKS
GHAHRAMANI, MD, MAHMOOD	BUCKS
GHALY, MD, NADER N	BERKS
GHATAK, MD, PETER K	NORTHAMPTON
GHATE, MD, SHARAD B	INDIANA
GHATNEKAR, MD, JAI V	ALLEGHENY
GHATNEKAR, MD, REVATI JAI	ALLEGHENY
GHEBRIAL, MINA S	STUDENT
GHIA, MD, PRADEEP S	NORTHAMPTON
GHOSH, MD, BIJOY K	PHILADELPHIA
GHOSH, MD, MARTHA S	PHILADELPHIA
GHOSH, SUMIT B	STUDENT
GHOSH, MD, SURESH C	PHILADELPHIA
GHOSH, MD, TARIT K	MONTOUR
GHOSHHAJRA, MD, KALYANMAY	ALLEGHENY
GIACCIA, MD, AMATO	BERKS
GIACOBBO, MD, JOHN N	PHILADELPHIA
GIAMBER, MD, SAMUEL R	NORTHAMPTON
GIAMMANCO, DO, PETER P	MONTGOMERY
GIAMMATTEI, MD, FRANK P	DELAWARE
GIANFAGNA, MD, WILLIAM J	SCHUYLKILL
GIANNASIO, MD, CHARLES V	PHILADELPHIA
GIANNI, PAMELA I	STUDENT
GIANNOPOULOS, MD, PETER H	CHESTER
GIANNOTTI, MD, BRADLEY F	MONTOUR
GIANNOTTO, MD, RICHARD P	WESTMORELAND
GIANNOUKOS, MD, EPHIGENIA K	DELAWARE
GIARDINO, MD, ANGELO P	PHILADELPHIA
GIBBLE, MD, JOAN W	YORK
GIBBLE, MD, LEON W	YORK
GIBBONS, MD, JACQUELYN H	DELAWARE
GIBBONS, MD, MICHAEL J	PHILADELPHIA
GIBBONS, MD, RICHARD E	PHILADELPHIA
GIBBONS, MD, ROBERT J	LUZERNE
GIBBONS, MD, WILLIAM P	BLAIR
GIBBS, MD, MICHAEL A	ALLEGHENY
GIBBS, MD, WINFIELD S	NORTHUMBERLAND
GIBNEY, SANDRA M	STUDENT
GIBSON, MD, F CLAY	WESTMORELAND
GIBSON, MD, JOSEPH M	LANCASTER
GIBSON, MD, KEITH	MONTOUR
GIBSON, MD, WILLIAM B	DELAWARE
GIBSON, MD, WILLIAM S	MONTOUR
GIBSON, MD, WILLIAM S	ALLEGHENY
GIBSON JR, MD, ROY L	ALLEGHENY
GIDDINGS, MD, NEIL A	MONTOUR
GIERING, MD, JOHN F	LUZERNE
GIERINGER, MD, ROBERTA L	BERKS
GIESECKE, MD, SUSAN B	BERKS
GIESZCZYKIEWICZ, MD, TADEUSZ A	ALLEGHENY
GIGA, MD, JUDITH P	ALLEGHENY
GILARSKY, MD, BRUCE P	YORK
GILBERT, MD, CHRISTIAN L	MONTOUR
GILBERT, DO, MAX	PHILADELPHIA
GILBERT, MD, ROBERT P	PHILADELPHIA
GILBERT, MD, STEVEN L	BERKS
GILBERTI, MD, FRANK F	ALLEGHENY
GILBERTI, MD, MICHAEL V	ALLEGHENY
GILDAY, MD, FRANK J	PHILADELPHIA
GILDEA, MD, JAMES E	DAUPHIN
GILFILLAN III, MD, A GEORGE	BERKS
GILFOIL, MD, JAMES H	DELAWARE
GILFORD, MD, LAWRENCE M	CLARION
GILGORE, MD, GARY S	PHILADELPHIA
GILHOOLEY, MD, MICHAEL G	STUDENT
GILL, MD, DONALD J	PHILADELPHIA
GILL, MD, ROBERT J	PHILADELPHIA
GILL III, MD, THOMAS J	ALLEGHENY
GILLEN, MD, GEORGE P	NORTHAMPTON
GILLEN, MD, JAMES P	MONTOUR
GILLESPIE, PETER A	STUDENT
GILLICK, MD, ALAN P	LACKAWANNA
GILLIGAN, MD, FRANK P	DELAWARE
GILLIO, MD, ROBERT G	LANCASTER
GILLIS, MD, ANGUS T	LANCASTER
GILLIS, MD, VICTORIA A	ARMSTRONG
GILLOTT, MD, ANTHONY R	BRADFORD
GILLUM, MD, DAVID F	TIOGA
GILLUM, MD, DIANE R	PHILADELPHIA
GILMAN, MD, EDWARD	ALLEGHENY
GILMAN, MD, PAUL B	PHILADELPHIA
GILMORE, MD, DOROTHEA M	CLEARFIELD
GILMORE, MD, FREDERICK R	CLEARFIELD
GILMORE, MD, GEORGE H	ALLEGHENY
GILMORE, MD, JAMES	ALLEGHENY
GILMORE JR, MD, HUGH R	DELAWARE
GILMOUR, MD, SARAH M	ALLEGHENY
GILOT, MD, JEAN M	BLAIR
GILROY, MD, ROBERT C	DAUPHIN
GINCHEREAU, MD, EUGENE H	ALLEGHENY
GINGRICH, MD, KERRY H	LEBANON
GINGRICH JR, MD, RUSSELL L	LEBANON
GINIECZKI, MD, CHESTER J	PHILADELPHIA
GINSBERG, MD, CRAIG ALLAN	PHILADELPHIA
GINSBERG, MD, DAVID K	PHILADELPHIA
GINSBERG, MD, GARY	BERKS
GINSBERG, MD, GENE H	LEHIGH
GINSBERG, MD, ILONA D	PHILADELPHIA
GINSBERG, MD, JOSEPH E	LAWRENCE
GINSBERG, DO, PHILLIP C	PHILADELPHIA
GINSBURG, MD, ABRAHAM	PHILADELPHIA
GINSBURG, MD, DAVID S	DELAWARE
GINSBURG, MD, HOWARD H	PHILADELPHIA
GINSBURG, MD, JOHN L	UNION
GINSBURG, MD, LEONARD H	DELAWARE
GINSBURG, MD, MICHAEL J	ALLEGHENY
GINSBURG, MD, NATHAN N	LAWRENCE
GINSBURG, DO, RICHARD E	PHILADELPHIA
GINSBURG, MD, SILAS	MONTGOMERY
GINSBURG, DO, STEVEN M	NORTHAMPTON
GINTER JR, MD, GEORGE C	LYCOMING
GIORDANO, MD, BERNICE R	PHILADELPHIA
GIORDANO, MD, JOSEPH A	MERCER
GIORDANO, MD, NICHOLAS D	LUZERNE
GIORGIO, MD, QUENTIN M	DELAWARE
GIOVANNELLI, MD, ANNE S	PHILADELPHIA
GIPSON, MD, LAWRENCE L	ALLEGHENY
GIRARD, MD, MEREDITH D	YORK
GIRARDO, MD, SALVATORE P	PHILADELPHIA
GIRDANY, MD, BERTRAM R	ALLEGHENY
GIRDANY, MD, DAVID S	ALLEGHENY
GIRDHAR, MD, RABINDRA	ALLEGHENY
GIRGIS, MD, HANY I	PHILADELPHIA
GIRMSCHEID, MD, LESLIE A	ALLEGHENY
GIRONE, MD, JOSEPH A C	BUCKS
GIRONE, MD, JOSEPH F	PHILADELPHIA
GIRSH, MD, LEONARD S	PHILADELPHIA
GIRTON, MD, KEITH E	CLINTON
GISH, MD, ROBIN D	LANCASTER
GISLASON, MD, G JOHN	PHILADELPHIA
GITLOW, MD, STUART	ALLEGHENY
GITTELMAN, MICHAEL A	STUDENT
GITTINGS, MD, PAUL E	ALLEGHENY
GITTLEMAN, MD, MARK A	LEHIGH
GITTLEMAN, MD, STANTON C	PHILADELPHIA
GITTLEN, MD, STANFORD D	BUCKS
GIUDICE, MD, VIRGINIO J	PHILADELPHIA
GIUGLIANO, MD, FRANK J	COLUMBIA
GIULIAN, MD, BERTRAND B	DAUPHIN
GIUNTOLI, MD, ROBERT L	PHILADELPHIA
GIURGIU, MD, DAN I N	PHILADELPHIA
GIVEN, MD, KENNETH M	PHILADELPHIA
GIVERTZ, ALAN R	STUDENT
GIZA-CULLEN, MICHELLE M	STUDENT
GLAD, MD, LAWRENCE J	ALLEGHENY
GLADE, JULIA L	STUDENT
GLADE, KIMBERLY	STUDENT
GLADSTONE, ADAM D	STUDENT
GLADSTONE, MD, JULIAN L	DELAWARE
GLAH, DO, JAMES J	BEDFORD
GLAH JR, MD, HENRY J	LANCASTER
GLANTZ, MD, ANDREW I	NORTHAMPTON
GLANZBERG, MD, PAULINE	MONTGOMERY
GLASER, MD, ALAN L	ERIE
GLASER, MD, BARRY L	MONTGOMERY
GLASKIN, MD, ALLEN	PHILADELPHIA
GLASS, MD, GREGORY L	BEAVER
GLASS, MD, PHILLIP	PHILADELPHIA
GLASS, MD, SAMUEL L	CAMBRIA
GLASSBURN, MD, EDWARD M	ALLEGHENY
GLASSBURN, MD, JOHN R	PHILADELPHIA
GLASSER, MD, STUART A	WESTMORELAND
GLASSMAN, MD, JOEL M	PHILADELPHIA
GLASSO, MD, LOUIS C	ALLEGHENY
GLAUSER, MD, ELINOR M	PHILADELPHIA
GLAUSER, MD, TERRY A	MONTGOMERY
GLAZER, MD, ROBERT M	PHILADELPHIA
GLAZERMAN, MD, LARRY R	LEHIGH
GLEASON, MD, JAMES A	ALLEGHENY
GLEDITSCH, MD, SCOTT D	ALLEGHENY
GLEESON, MD, GEORGE H	ALLEGHENY
GLEESON, MD, GEORGE L	DAUPHIN
GLEESON, MD, MICHAEL F	LACKAWANNA
GLEESON, SEAN P	STUDENT
GLICINI, MD, ROBERT L	LUZERNE
GLICK, MD, ABRAHAM	PHILADELPHIA
GLICK, MD, HAROLD M	ALLEGHENY
GLICK, MD, KENNETH A	ALLEGHENY
GLICK, MD, MARK R	DAUPHIN
GLICK, MD, RONALD M	ALLEGHENY
GLIELMI, DO, VINCENT D	LANCASTER
GLIKMAN, MD, NADEZHDA	PHILADELPHIA
GLORIOSO, MD, ROBERT C	YORK
GLOSSER, MD, WILLIAM E	BERKS
GLOVER, MD, DONNA J	PHILADELPHIA
GLOWACKI, MD, DAVID M	ALLEGHENY
GLOWACKI, MD, FRANCIS L	VENANGO
GLUCKMAN, MD, ROBERT J	ALLEGHENY
GLUNK, MD, DANIEL J	LYCOMING
GLUNK, MD, RICHARD P	MONTGOMERY
GMUER, MD, PAUL J	ERIE
GNAU, MD, CHARLES R	LEBANON
GNEGY, MD, RICHARD	ALLEGHENY
GO, MD, ALFONZO H L	LYCOMING
GO, BRIAN M	STUDENT
GO, MD, JOSEPHINE L	DELAWARE
GO, MD, WELLES P	PHILADELPHIA
GO JR, MD, WILLIAM C	CAMBRIA
GOBEL, MD, REGINALD T	YORK
GOCHNAUER-VEINO, JOYCE E	STUDENT
GOCHOCO, MD, JACINTO J	YORK
GOCIAL, MD, BENJAMIN	PHILADELPHIA
GODBOUT, MD, BRETT P	NORTHAMPTON
GODDARD JR, MD, JAMES E	LANCASTER
GODFREY, DO, CRAIG R	CRAWFORD
GODFREY, MD, DAVID K	MCKEAN
GODINEZ, MD, RODOLFO I	PHILADELPHIA
GODLA, MD, GREGORY J	ALLEGHENY
GODLEY, MD, JOANNE	PHILADELPHIA
GODSHALL, MD, RICHARD W	BUCKS
GODSHALL, MD, STANLEY M	LANCASTER
GOEBERT, MD, HERBERT W	CHESTER
GOEDECKE, MD, JOHN B	DAUPHIN
GOEHRING, MD, DONALD E	BUTLER
GOEHRING, MD, WALTER O	ALLEGHENY
GOEPP, MD, CARLA E	PHILADELPHIA
GOESER, MD, EUGENE	DELAWARE
GOESSLER, MD, MARY C	ALLEGHENY
GOETZ, MD, KATHARINE M	ALLEGHENY
GOFF, MD, ELIZABETH	LEHIGH
GOFF, MD, SHARON E	CAMBRIA
GOGLIN, MD, BRETT W	FRANKLIN
GOKHALE, MD, SUDHIR B	ERIE
GOLANI, MD, UMESH A	ALLEGHENY
GOLD, MD, ALLAN	PHILADELPHIA
GOLD, MD, BARBARA W	PHILADELPHIA
GOLD, MD, HENRY J	PHILADELPHIA
GOLD, MD, HERMAN	DELAWARE
GOLD, MD, JACK	ERIE
GOLD, MD, MARLA J	PHILADELPHIA
GOLD, MD, MORRIE G	CHESTER
GOLDBACHER, MD, ARLEEN J	PHILADELPHIA
GOLDBACHER, MD, LAWRENCE R	PHILADELPHIA
GOLDBERG, MD, AMY J	PHILADELPHIA
GOLDBERG, MD, ANDREW L	ALLEGHENY
GOLDBERG, MD, BARRY B	PHILADELPHIA
GOLDBERG, MD, GARY	PHILADELPHIA
GOLDBERG, MD, HARRY	PHILADELPHIA
GOLDBERG, MD, HARVEY E	BUCKS
GOLDBERG, MD, HOWARD E	PHILADELPHIA
GOLDBERG, MD, LARRY H	PHILADELPHIA
GOLDBERG, MD, LISA A	ALLEGHENY
GOLDBERG, MD, LOUIS	MONTGOMERY
GOLDBERG, MD, MICHAEL E	BUCKS
GOLDBERG, DO, RICHARD A	MONTGOMERY
GOLDBERG, MD, RICHARD E	PHILADELPHIA
GOLDBERG, MD, RICHARD M	MONTOUR
GOLDBERG, MD, ROCHELLE	PHILADELPHIA
GOLDBERG, MD, SHELDON	PHILADELPHIA
GOLDBERG, MD, TODD H	PHILADELPHIA
GOLDBERGER, MD, ARNOLD	PHILADELPHIA
GOLDBLATT, CURTIS S	STUDENT
GOLDBLATT, MD, SIDNEY A	CAMBRIA
GOLDBLUM, MD, ABRAHAM D	ALLEGHENY
GOLDBLUM, MD, KENNETH D	CHESTER
GOLDBLUM, MD, LEE J	ALLEGHENY
GOLDBLUM, MD, ORIN M	ALLEGHENY
GOLDBLUM, MD, RAYMOND W	ALLEGHENY
GOLDBURGH, MD, WARREN P	PHILADELPHIA
GOLDEN, MD, MANO R	MONTGOMERY
GOLDEN, MD, MICHAEL A	PHILADELPHIA
GOLDEN, MD, MICHAEL F	CHESTER
GOLDENBERG, MD, MARC R	MONTGOMERY
GOLDENER, MD, JOHN F	MONTGOMERY
GOLDFARB, MD, DANIEL D	LEHIGH
GOLDFARB, MD, HAROLD J	LEHIGH
GOLDFARB, MD, I WILLIAM	ALLEGHENY
GOLDFARB, MD, RICHARD M	BUCKS
GOLDFEDER, MD, WARREN J	LUZERNE
GOLDFINE, MD, ALAN	CHESTER
GOLDIN, MD, RALPH J	LANCASTER
GOLDING, MD, DANIEL M	PHILADELPHIA
GOLDING, MD, IRVIN M	ALLEGHENY
GOLDMAN, DO, ANDREW M	NORTHAMPTON
GOLDMAN, MD, ARTHUR	DELAWARE
GOLDMAN, MD, GARY L	LANCASTER
GOLDMAN, MD, H WARREN	PHILADELPHIA
GOLDMAN, MD, IRVING S	ALLEGHENY
GOLDMAN, MD, MARVIN	PHILADELPHIA
GOLDMAN, MICHAEL S	STUDENT
GOLDMAN, MD, RICHARD J	DELAWARE
GOLDMAN, MD, ROBERT F	FRANKLIN
GOLDMAN, MD, RUSSEL W	BEAVER
GOLDMAN, MD, SCOTT M	PHILADELPHIA
GOLDMAN, MD, STANLEY R	DAUPHIN
GOLDMAN, MD, STEPHEN M	PHILADELPHIA
GOLDMAN, STEVEN A	STUDENT
GOLDMAN, SUSAN G	STUDENT
GOLDMANN, MD, BONNIE J	PHILADELPHIA
GOLDNER, MD, DAVID B	LEHIGH
GOLDNER, DO, JONATHAN A	MONROE
GOLDSBERRY, MD, DAVID T	ERIE
GOLDSCHMIDT, MD, HERBERT	MONTGOMERY
GOLDSCHMIDT, MD, PAULINE	BLAIR
GOLDSCHMIDT JR, MD, JOSEPH C	DELAWARE
GOLDSMITH, MD, CHARLES P	LEHIGH
GOLDSMITH, MD, JOYCE	PHILADELPHIA
GOLDSMITH, MD, KATHLEEN M	CHESTER
GOLDSTEIN, MD, ARNOLD L	BUCKS
GOLDSTEIN, MD, ARTHUR M	PHILADELPHIA
GOLDSTEIN, MD, BERNARD	PHILADELPHIA
GOLDSTEIN, MD, CHARLES D	PHILADELPHIA
GOLDSTEIN, MD, DAVID M	ALLEGHENY
GOLDSTEIN, MD, ELLIOTT J	ALLEGHENY
GOLDSTEIN, MD, ERROLL J	LUZERNE
GOLDSTEIN, MD, FRANZ	PHILADELPHIA
GOLDSTEIN, MD, HEIDI J	PHILADELPHIA
GOLDSTEIN, MD, JACOB	PHILADELPHIA
GOLDSTEIN, MD, JEFFREY E	NORTHAMPTON
GOLDSTEIN, MD, JEROME	PHILADELPHIA
GOLDSTEIN, MD, LARRY E	PHILADELPHIA
GOLDSTEIN, MD, MARC F	PHILADELPHIA
GOLDSTEIN, MD, MARK R	DELAWARE
GOLDSTEIN, MD, MORTON L	ALLEGHENY
GOLDSTEIN, MD, NEIL H	CHESTER
GOLDSTEIN, MD, NORMAN A	CHESTER
GOLDSTEIN, MD, PHILIP D	MONTGOMERY
GOLDSTEIN, MD, RICHARD S	BUCKS
GOLDSTEIN, MD, ROBERT C	PHILADELPHIA
GOLDSTEIN, MD, SCOTT D	PHILADELPHIA
GOLDSTEIN, DO, STEVEN H	PHILADELPHIA
GOLDSTONE, MD, SHELDON B	LACKAWANNA
GOLDSTROHM, MD, GREGG L	WESTMORELAND
GOLDSTROHM, MD, ROBERT G	INDIANA
GOLDWEIN, MD, MANFRED I	PHILADELPHIA
GOLIO, MD, ANTHONY G	WESTMORELAND
GOLLA, MD, SARASWATHI K	ALLEGHENY
GOLLATZ, MD, JOHN W	ALLEGHENY
GOLLOMP, MD, STEPHEN M	DELAWARE
GOLOMB, MD, NORMAN G	WASHINGTON
GOLTZ, MD, GERALD M	ALLEGHENY
GOMAR, MD, ALFONSO A	LACKAWANNA
GOMBAR, MD, EDWARD F	LACKAWANNA
GOMBERG, BRUCE F C	STUDENT
GOMBERG, MD, JACK A	PHILADELPHIA
GOMBERG, MD, JONATHAN D	MONTGOMERY
GOMEZ, MD, ANSELMO R	INDIANA
GOMEZ, MD, ELLIS E	ERIE
GOMEZ, MD, LUIS L	CRAWFORD
GOMEZ, MD, SOPHIE	ALLEGHENY
GONGLOFF, MARIANNE	INDIANA
GONICK, MD, PAUL	PHILADELPHIA
GONNELLA, MD, JOSEPH S	PHILADELPHIA
GONSKY, DO, MARK A	LUZERNE
GONZALES, MD, ALBERT	BUCKS
GONZALES, MD, JERRY M	PHILADELPHIA
GONZALEZ, MD, ALEJANDRO R	ALLEGHENY
GONZALEZ, MD, DIEGO J	YORK
GONZALEZ, MD, JOSE L	SCHUYLKILL
GONZALEZ, MD, LUIS C	ALLEGHENY
GONZALEZ, MD, RENE M	ALLEGHENY
GONZALEZ-FLORIN, MD, RUBEN A	BLAIR
GONZALEZ-MASO, MD, GUILLERONO E	PHILADELPHIA
GONZE, MD, MARK D	ALLEGHENY
GOOD, MD, DANIEL C	LANCASTER
GOOD, MD, GARY R	DAUPHIN
GOOD, MD, HARRY S	LEHIGH
GOOD, MD, MILTON S	LANCASTER
GOOD, MD, ROBERT P	MONTGOMERY
GOOD, MD, VANCE A	BRADFORD
GOODE JR, MD, JOHN G	PHILADELPHIA
GOODENOW, MD, ELIZABETH L	LYCOMING
GOODKIN, MD, MICHAEL B	DELAWARE
GOODMAN, MD, ADAM J	PHILADELPHIA
GOODMAN, MD, BRUCE	DAUPHIN
GOODMAN, MD, BRUCE A	BUCKS
GOODMAN, MD, CARL R	MONTGOMERY
GOODMAN, MD, DAVID A	MONTGOMERY
GOODMAN, MD, DAVID B	FAYETTE
GOODMAN, MD, GEORGE B	ALLEGHENY
GOODMAN, JAY D	STUDENT
GOODMAN, MD, LOWELL I	DELAWARE
GOODMAN, MD, MARK A	ALLEGHENY
GOODMAN, MATTHEW A	STUDENT
GOODMAN, MD, MICHAEL S	BUCKS
GOODMAN, MD, RICHARD A	ALLEGHENY
GOODMAN, MD, SANFORD M	MONTGOMERY
GOODNER, MD, DAVID M	PHILADELPHIA
GOODREAU, MD, JAMES J	LEHIGH
GOODRICH, MD, DAVID C	NORTHAMPTON
GOODRICH, MD, JACK K	ERIE
GOODRICH, MD, KENNETH B	ALLEGHENY
GOODSTEIN, MD, MICHAEL H	PHILADELPHIA
GOODWORTH, MD, JOHN H	ALLEGHENY
GOONEWARDENE, SHANTH A	STUDENT
GOOSENBERG, MD, ERIC B	MONTGOMERY
GOPAL, MD, KRISHNAN A	ALLEGHENY
GOPAL, MD, SARITA	PHILADELPHIA
GOPAL, MD, T A	LEHIGH
GOPALANI, MD, AZIZ A	ALLEGHENY
GOPALANI, MD, USHA	ALLEGHENY
GOPLERUD, MD, ELIZABETH J	CARBON
GOPPELT, MD, JOHN W	MONTGOMERY
GORACCI SLIMAK, MD, GRACE	PHILADELPHIA
GORALCZYK JR, MD, EDWARD J	ALLEGHENY
GORBY, MD, DAVID R	COLUMBIA
GORBY, DO, WILLIAM G	COLUMBIA
GORDEUK, MD, DANIEL S	CENTRE
GORDIN, MD, STEPHEN J	PHILADELPHIA
GORDON, ADAM J	STUDENT
GORDON, MD, ALAN D	MIFFLIN/JUNI
GORDON, ALEXIA L	STUDENT
GORDON, MD, ARTHUR E	MONTGOMERY
GORDON, MD, BRIGID A	PHILADELPHIA
GORDON, MD, CHARLES A	LEHIGH
GORDON, DO, DANIEL S	JEFFERSON
GORDON, MD, DAVID A	LEHIGH
GORDON, MD, DAVID A	PHILADELPHIA
GORDON, MD, DUDLEY R	DAUPHIN

GORDON, MD, ELIZABETH H	ALLEGHENY
GORDON, MD, GARY V	MONTGOMERY
GORDON, MD, GERALD	MONTOUR
GORDON, MD, HAROLD E	WESTMORELAND
GORDON, MD, HAROLD M	DELAWARE
GORDON, MD, ISADORE	CHESTER
GORDON, MD, JAMES K	BEDFORD
GORDON, MD, JEROLD S	ALLEGHENY
GORDON, JONATHAN C	STUDENT
GORDON, MD, JOSEPH S	DELAWARE
GORDON, MD, LEONARD F	MONTGOMERY
GORDON, MD, MICHAEL E	BERKS
GORDON, MD, MICHAEL J	LEHIGH
GORDON, MD, MILTON S	WESTMORELAND
GORDON, MD, MURRAY B	ALLEGHENY
GORDON, NANCY D	STUDENT
GORDON, MD, ROBERT A	DAUPHIN
GORDON, MD, ROBERT H	PHILADELPHIA
GORDON, DO, SANFORD A	WASHINGTON
GORDON, MD, SUSAN J	PHILADELPHIA
GORDON, MD, TOM J	ALLEGHENY
GORDON, MD, WILLIAM S	DAUPHIN
GORDON JR, MD, KENNETH H	MONTGOMERY
GORE, HERMAN C	STUDENT
GOREN, MD, ELIHU N	MONTGOMERY
GOREN, MD, LAWRENCE J	PHILADELPHIA
GOREN, MD, ROBERT A	PHILADELPHIA
GOREN, MD, RONALD C	PHILADELPHIA
GOREN, MD, STANLEY E	PHILADELPHIA
GORIN, MD, MICHAEL B	ALLEGHENY
GORMAN, MD, ROBERT C	PHILADELPHIA
GORMAN, SEAN J	STUDENT
GORMAN, MD, TIMBER H	STUDENT
GORMAN-CATTON, MD, JOHANNA H	CHESTER
GORMLEY, MD, ROBERT A	ALLEGHENY
GORMLEY, TIMOTHY S	STUDENT
GORRY, MD, JOHN D	DELAWARE
GOSFIELD JR, MD, EDWARD	PHILADELPHIA
GOSLING, MD, AMY A	ALLEGHENY
GOSSAT, MD, DAVID M	ALLEGHENY
GOSZTONYI JR, MD, RUDOLPH E	NORTHAMPTON
GOTCHEL, MD, MARK P	MONROE
GOTH, MD, JOSEPH H	ALLEGHENY
GOTKIEWICZ, EDWARD M	STUDENT
GOTLIEB, MD, JERRY	MONTGOMERY
GOTTHEIL, MD, EDWARD	PHILADELPHIA
GOTTLIEB, MD, HARRY	PHILADELPHIA
GOTTLIEB, MD, JEROME I	LANCASTER
GOTTLIEB, MD, MICHAEL A	ALLEGHENY
GOTTLIEB, MD, PHILIP M	PHILADELPHIA
GOTTLIEB, MD, ROBERT J	LANCASTER
GOTTLIEB, MD, RONALD S	PHILADELPHIA
GOTTLIEB, MD, STANLEY	PHILADELPHIA
GOTTSCHALL, MD, DANIEL S	STUDENT
GOTTSHALL, MD, SAMUEL C	LACKAWANNA
GOULD, MD, RICHARD B	PHILADELPHIA
GOULD JR, MD, JOHN H	PHILADELPHIA
GOULDIN, MD, JUDITH A	LYCOMING
GOULEY, MD, BENJAMIN A	PHILADELPHIA
GOURASH, MD, LEONA	ALLEGHENY
GOUW, MD, CHRISTOPHER B	CARBON
GOWDEY, MD, M AGNES	PHILADELPHIA
GOWEN, MD, GEORGE F	PHILADELPHIA
GOWING, MD, JEAN	PHILADELPHIA
GOYAL, MD, ANIL K	CUMBERLAND
GOYNE, MD, RUTH G	DELAWARE
GOZUM, MD, CARMEN Z	NORTHAMPTON
GRAB, MD, EDMUNDO M	BLAIR
GRABAR, MD, JOYCE M	PHILADELPHIA
GRABELSKY, MD, STEPHEN A	PHILADELPHIA
GRABIAK, MD, GREGORY D	WESTMORELAND
GRABIAS, MD, STANLEY L	BERKS
GRABOWSKI, MD, MARIE A	LUZERNE
GRABOYES, MD, ARNOLD B	LYCOMING
GRACE, MD, HELEN K	PHILADELPHIA
GRACE, MD, JAMES J	SUSQUEHANNA
GRACEY, MD, JACK G	YORK
GRAD, MD, CHARLES T	LACKAWANNA
GRAD, MD, L CHRISTINE	DELAWARE
GRADY, CHRISTOPHER K	STUDENT
GRADY, MD, PATRICK J	LACKAWANNA
GRADY, MD, THOMAS A	PHILADELPHIA
GRAEFFE, MD, ESTELLA F	MONTGOMERY
GRAF, MD, KENNETH W	DAUPHIN
GRAFF, MD, DANIEL M	ALLEGHENY
GRAHAM, MD, BARRY E	BERKS
GRAHAM, DO, E JOAN	LUZERNE
GRAHAM, MD, GARTH K	PHILADELPHIA
GRAHAM, MD, MARK G	PHILADELPHIA
GRAHAM, MD, NATHANIEL L	MCKEAN
GRAHAM, STEPHEN J	STUDENT
GRAHAM, MD, THOMAS H	CHESTER
GRAHAM, MD, THOMAS R	ALLEGHENY
GRAHAM III, MD, WILLIAM P	CUMBERLAND
GRAMMES, MD, CHARLES F	MONTOUR
GRANA, MD, PHILIP C	BEDFORD
GRANA, MD, VICENTE P	PHILADELPHIA
GRANADOS, MD, NICANOR G	BERKS
GRANADOS, MD, SUZITA N	BERKS
GRANATO, MD, JEROME E	ALLEGHENY
GRANDIS, MD, DONALD J	ALLEGHENY
GRANDIS, MD, JENNIFER R	ALLEGHENY
GRANDON, MD, RAYMOND C	DAUPHIN
GRANETT, MD, JEFFREY R	DELAWARE
GRANICK, MD, MARK S	PHILADELPHIA
GRANITO, MD, CHARLES D	DAUPHIN
GRANOWITZ, MD, SAMUEL P	ALLEGHENY
GRANSON, MD, MARC A	NORTHAMPTON
GRANT, MD, ALISTAIR M	LANCASTER
GRANT, MD, B DAVID	DELAWARE
GRANT, MD, KATHLEEN J	ALLEGHENY
GRASSI, MD, JOSEPH J	LEHIGH
GRATCH, MD, MICHAEL J	MONTGOMERY
GRATZ, DO, IRWIN	PHILADELPHIA
GRATZ, MD, RICHARD E	LACKAWANNA
GRAUEL JR, MD, THEODORE A	LAWRENCE
GRAVES, MD, LYNDA C S	SCHUYLKILL
GRAVES, MD, SALINA D	PHILADELPHIA
GRAVES, MD, VAUGHAN C	PHILADELPHIA
GRAVES JR, MD, BEVERLY	PHILADELPHIA
GRAY, BRADFORD C	STUDENT
GRAY, MD, CYNTHIA A	ALLEGHENY
GRAY, MD, DAVID W	UNION
GRAY, MD, FRIEDA G	PHILADELPHIA
GRAY, MD, HERBERT M	BEAVER
GRAY, MD, JERRY L	CAMBRIA
GRAY, DO, JOHN M	NORTHAMPTON
GRAY, MD, LOUIS P	LANCASTER
GRAY, MD, ROBERT T	FRANKLIN
GRAY III, MD, SAMUEL	ALLEGHENY
GRAY JR, MD, FRANK D	PHILADELPHIA
GRAY JR, MD, GEORGE H	ALLEGHENY
GRAYSON, MD, MITCHELL J	BRADFORD
GRAYUM, MD, BRADLEY P	DELAWARE
GRAZIANI, MD, VIRGINIA	PHILADELPHIA
GRAZIANO, MD, LINDA M	BUCKS
GREALISH, MD, ROBERT R	ALLEGHENY
GREATHOUSE, MD, MARK K	ALLEGHENY
GRECO, MD, FRANK D	ALLEGHENY
GRECO, MD, JEFFREY M	NORTHUMBERLAND
GRECO, MD, JONATHAN P	DELAWARE
GRECO, MD, RICHARD J	ALLEGHENY
GRECO, MD, ROBERT M	SCHUYLKILL
GRECO, MD, TIMOTHY M	PHILADELPHIA
GRECO, MD, TOBY A	PHILADELPHIA
GRECO, MD, VICTOR F	LUZERNE
GREEN, ADRIENNE L	STUDENT
GREEN, DO, ALFRED I	PHILADELPHIA
GREEN, MD, BARRY P	MONTGOMERY
GREEN, MD, BRADFORD	BUCKS
GREEN, CANDACE C	STUDENT
GREEN, MD, CHARLES	SCHUYLKILL
GREEN, MD, GEORGE R	MONTGOMERY
GREEN, MD, JOSEPH E	CUMBERLAND
GREEN, JOSHUA T	STUDENT
GREEN, MD, LAWRENCE	DELAWARE
GREEN, MD, LELAND J	MONTGOMERY
GREEN, MD, M EDWIN	DAUPHIN
GREEN, MD, MAYER A	ALLEGHENY
GREEN, MD, RICHARD L	ALLEGHENY
GREEN, DO, ROBERT L	DAUPHIN
GREEN, MD, ROBERT M	ALLEGHENY
GREEN, MD, ROY	SCHUYLKILL
GREEN, MD, THOMAS J	CUMBERLAND
GREEN, MD, TRACEY D	BLAIR
GREEN, MD, WILLIAM	PHILADELPHIA
GREEN, MD, WILLIAM H	DELAWARE
GREEN III, MD, JOSEPH E	CUMBERLAND
GREEN JR, MD, WILLIAM T	ALLEGHENY
GREENACRE, MD, JUDITH K	PHILADELPHIA
GREENAWALD, MD, HENRY A	DAUPHIN
GREENAWALT, MD, ROBERT G	FRANKLIN
GREENBARG, MD, JEFFREY B	PHILADELPHIA
GREENBAUM, MD, ARTHUR M	WARREN
GREENBAUM, MD, CHARLES H	PHILADELPHIA
GREENBAUM, MD, JAMES K	ARMSTRONG
GREENBAUM, MD, MARVIN H	MONTGOMERY
GREENBAUM, MD, ROY L	BUCKS
GREENBERG, ADAM S	STUDENT
GREENBERG, MD, BRAM	MONTGOMERY
GREENBERG, MD, HOWARD E	STUDENT
GREENBERG, MD, JACK O	PHILADELPHIA
GREENBERG, MD, LEONARD F	PHILADELPHIA
GREENBERG, DO, MARNA RAYL	LEHIGH
GREENBERG, MD, MICHAEL J	MONROE
GREENBERG, MD, MICHAEL R	CLINTON
GREENBERG, MD, RICHARD E	MONTGOMERY
GREENBERG, MD, RICHARD H	PHILADELPHIA
GREENBERG, MD, RICHARD M	PHILADELPHIA
GREENBERG, MD, ROBERT N	BERKS
GREENBERG, MD, STEVEN M	PHILADELPHIA
GREENBERG, MD, STEVEN M	JEFFERSON
GREENBERG, MD, WAYNE V	ALLEGHENY
GREENE, MD, DONALD H	LYCOMING
GREENE, MD, JAN P	DELAWARE
GREENE, MD, JEFFREY M	MONTGOMERY
GREENE, MD, JOSEPH S	MONTOUR
GREENE, MD, LUCILLE T	BERKS
GREENE, MD, NEIL A	LANCASTER
GREENE, MD, RICHARD J	BERKS
GREENE, MD, ROBERT F	INDIANA
GREENE, MD, RONALD B	PHILADELPHIA
GREENE, MD, THOMAS E	MONTGOMERY
GREENFIELD, MD, HYMAN	PHILADELPHIA
GREENFIELD, MD, LAWRENCE S	MONTOUR
GREENFIELD, MD, VAL S	PHILADELPHIA
GREENLEE, MD, DANIEL P	GREENE
GREENLER, MD, DANIEL P	ALLEGHENY
GREENSMITH, MD, J ERIC	DAUPHIN
GREENSPAN, MD, AARON B	ALLEGHENY
GREENSPAN, MD, ALLAN M	PHILADELPHIA
GREENSPAN, MD, BRUCE M	NORTHAMPTON
GREENSPAN, MD, HERBERT S	MONTGOMERY
GREENSPAN, MD, MITCHELL M	BUCKS
GREENSPON, MD, SAMUEL E	MONTGOMERY
GREENSPUN, ASHLEY L	STUDENT
GREENWALD, MD, DAVID W	LUZERNE
GREER III, MD, ROBERT B	DAUPHIN
GREGG, MD, CHARLES E	PHILADELPHIA
GREGG, MD, GRACE S	ALLEGHENY
GREGG, MD, JOHN S	ALLEGHENY
GREGO, MD, J GREGORY	ALLEGHENY
GREGORY, MD, GEORGE W	BERKS
GREGORY, MD, ROBERT E	ALLEGHENY
GREIFER, JONATHAN R	STUDENT
GREIM, MD, CHARLES C	ALLEGHENY
GREINER, MD, ANN S	DAUPHIN
GRENNAN JR, MD, M JOSEPH	ALLEGHENY
GRENVIK, MD, AKE N	ALLEGHENY
GRENVIK, MD, STEFAN J	ALLEGHENY
GRESS, MD, FRANCIS A	NORTHAMPTON
GRESS, MD, GORDON A	CAMBRIA
GRESS, MD, ROBERT E	LANCASTER
GRESS, MD, WILLIAM W	CAMBRIA
GRESSEN, ERIC L	STUDENT
GRETH, MD, WARREN E	BERKS
GREWAL, MD, HARPREET S	DELAWARE
GREYBUSH, MD, JOSEPH N	LEHIGH
GRIBB, MD, JOHN J	BUCKS
GRIBB, MD, JOSEPH C	DAUPHIN
GRIBIK, MD, MICHAEL	ALLEGHENY
GRIDER, NATALIE M	STUDENT
GRIEBEL, STEPHEN R	STUDENT
GRIECO, MD, ROBERT L	BEAVER
GRIEBMER, MD, PAUL D	LUZERNE
GRIEVESON JR, MD, JOHN N	PHILADELPHIA
GRIFF, MD, LEONARD C	DAUPHIN
GRIFF, MD, ROBERTA E	DAUPHIN
GRIFFEN, MD, HELEN S	VENANGO
GRIFFEN, MD, R HOWARD	VENANGO
GRIFFEN JR, MD, WARD O	PHILADELPHIA
GRIFFIN, MD, STEVEN P	INDIANA
GRIFFIN, MD, THOMAS D	PHILADELPHIA
GRIFFIN JR, DO, ROBERT M	NORTHAMPTON
GRIFFITH, MD, ANNETTE Y	BUCKS
GRIFFITH, MD, CHARLES Q	PHILADELPHIA
GRIFFITH, MD, GLENN G	CAMBRIA
GRIFFITH, MD, JOHN R	PHILADELPHIA
GRIFFITH, RENNY	STUDENT
GRIFFITH, MD, SCOTT A	STUDENT
GRIFFITHS, JON D	STUDENT
GRILL, MD, HOWARD P	ALLEGHENY
GRILL, MD, WINFRED E	JEFFERSON
GRIM, MD, MARK D	BERKS
GRIM, MD, TRACEY P	YORK
GRIMES, MD, CLARENCE W	GREENE
GRIMM, MD, JAMES T	ALLEGHENY
GRIMM, MARK W	STUDENT
GRINDLINGER, MD, JONATHAN L	LYCOMING
GRISKA, MD, JOEL A	PHILADELPHIA
GRISSOM, MD, CHRISTINE A	PHILADELPHIA
GROFF, MD, HENRY C	ALLEGHENY
GROGAN, MD, WENDELL A	PHILADELPHIA
GROH, MD, JOHN R	LEBANON
GROHSMAN, MD, JONATHAN M	MONTGOMERY
GROLEAU, MD, GEORGE E	LANCASTER
GROLMAN, MD, DENNIS M	YORK
GROSH, MD, JOHN L	LANCASTER
GROSH, MD, JOSEPH W	LANCASTER
GROSH, MD, PAUL R	LANCASTER
GROSH, MD, WILLIAM B	LANCASTER
GROSH, MD, WILLIAM K	LANCASTER
GROSKY, MD, MURRAY B	LEBANON
GROSS, MD, BENJAMIN A	PHILADELPHIA
GROSS, MD, CRAIG F	YORK
GROSS, MD, EDWARD A	STUDENT
GROSS, MD, LAWRENCE S	BERKS
GROSS, MD, MITCHELL J	LUZERNE
GROSS, MD, PAUL	ALLEGHENY
GROSS, MD, PAUL R	PHILADELPHIA
GROSS, MD, PETER G	MONTGOMERY
GROSS, MD, ROBERT	PHILADELPHIA
GROSSBERG, MD, MICHAEL F	FRANKLIN
GROSSINGER, DO, BRUCE H	DELAWARE
GROSSMAN, MD, ALAN R	MONTGOMERY
GROSSMAN, MD, ERIC J	PHILADELPHIA
GROSSMAN, MD, GILBERT	PHILADELPHIA
GROSSMAN, MD, I WILLIAM	FAYETTE
GROSSMAN, MD, IRA C	LUZERNE
GROSSMAN, LINDA B	STUDENT
GROSSMAN, MD, PERRY	CHESTER
GROSSMAN, MD, RONALD M	DAUPHIN
GROSSMAN, MD, SHEILA S	MONTGOMERY
GROSSMAN, MD, STANLEY J	ALLEGHENY
GROTZINGER, MD, MARGARET L	DAUPHIN
GROTZINGER, MD, PAUL J	PHILADELPHIA
GROVE, MD, BRUCE A	YORK
GROVE, MD, GLENN P	YORK
GROVE, MD, RUSSELL E	YORK
GROVE, MD, WILLIAM K	YORK
GROVE JR, MD, DALE A	NORTHAMPTON
GROVER, MD, JOSEPH G	PHILADELPHIA
GROVER, MD, STEVEN M	PHILADELPHIA
GROVER, MD, SUKHDEV S	ALLEGHENY
GRUBB, MD, WILLARD Y	BERKS
GRUBBS, MD, ROBERT M	ALLEGHENY
GRUBER, MD, JOHN W	BERKS
GRUEN, MD, GARY S	ALLEGHENY
GRUENBERG, MD, ALAN M	PHILADELPHIA
GRUENER, MD, DANIEL M	PHILADELPHIA
GRUMET, MD, BERNARD A	ALLEGHENY
GRUNBERG, MD, ROBERT W	NORTHAMPTON
GRUNER, MD, SAM E	ALLEGHENY
GRUNT, MD, RICHARD F	PHILADELPHIA
GRUNWALD, MD, JUAN E	PHILADELPHIA
GRUS, BRIAN A	STUDENT
GRYCZKO, MD, GERALD A	LACKAWANNA
GSCHWEND III, MD, PAUL	LANCASTER
GU, MD, JENG Y	BRADFORD
GUADAGNO, MD, ROBERT C	BEAVER
GUAGLIARDO, DO, JOSEPH P	BUCKS
GUANZON, MD, DANILO L	CRAWFORD
GUARDERAS, MD, JUAN C	ALLEGHENY
GUARINI, MD, PASQUALE S	DELAWARE
GUARINO, MD, EDWARD F	LEHIGH
GUARINO, MD, JAMES C	PHILADELPHIA
GUARINO, MD, JULIUS M	DELAWARE
GUARNIERI, MD, DAVID M	PHILADELPHIA
GUARNIERI, MD, KATHLEEN M	PHILADELPHIA
GUASTAVINO, MD, THOMAS D	SCHUYLKILL
GUEHL JR, DO, JOHN J	ALLEGHENY
GUEHL SR, MD, JOHN J	ALLEGHENY
GUELBENZU, MD, NELSON O	CAMBRIA
GUELCHER, MD, ROBERT T	ERIE
GUELIG, MD, EDMUND P	TIOGA
GUENTER, MD, FRITZ E	MCKEAN
GUERGAWI, MARK F	STUDENT
GUERRA, MD, CORAZON A	NORTHAMPTON
GUERRA, MD, REYNALDO C	NORTHAMPTON
GUEBON, MD, EMERITA T	PHILADELPHIA
GUEBT, DO, DENNIS M	PHILADELPHIA
GUEBT, DO, MARGARET A	PHILADELPHIA
GUIDONE, PAUL L	STUDENT
GUILFOIL, MD, DANIEL S	PHILADELPHIA
GUILLARD, MD, FRANK	CENTRE
GUINTO, MD, JOSE C	ALLEGHENY
GUIRGUIS, MD, MORRIS F	DELAWARE
GUIRNALDA-CASTRO, MD, NEMESIA G	MONTGOMERY
GUISER, MD, LYNN G	MIFFLIN/JUN
GUISTWITE, MD, KENNETH R	CUMBERLAND
GULATI, MD, AMAR N	MONTGOMERY
GULATI, PRIYA	STUDENT
GULICK, MD, THOMAS H	MONROE
GULLOTTI, MD, MICHAEL J	PHILADELPHIA
GULOTTA, MD, PAUL	LEHIGH
GUMERMAN, MD, LEWIS W	ALLEGHENY
GUMINA, MD, THOMAS F	DELAWARE
GUMM, MD, EDWARD A	WESTMORELAND
GUMNIT, MD, ROBERT Y	PHILADELPHIA
GUMP, MD, ROBERT B	ALLEGHENY
GUNDER, MD, SCOTT A	LEBANON
GUNDERSON, MD, ROBERT L	LUZERNE
GUNDUZ, MD, PAULA A	ERIE
GUNNERSON, MD, HELENA B	ALLEGHENY
GUNSTER, MD, GERALD D	LUZERNE
GUNTHER, DAVID M	STUDENT
GUP, MD, DANIEL I	ALLEGHENY
GUPTA, AMIT	STUDENT
GUPTA, MD, CHITRA L	PHILADELPHIA
GUPTA, MD, GIRIWARLAL	MONROE
GUPTA, MD, KRISHNA G	WESTMORELAND
GUPTA, MD, NAND K	BUCKS
GUPTA, MD, NEENA	PHILADELPHIA
GUPTA, MD, PRAMILA P	NORTHAMPTON
GUPTA, MD, VED P	PHILADELPHIA
GURGUN, MD, MELIH	ALLEGHENY
GURLAND, IRA A	STUDENT
GURMAN, MD, ANDREW W	BLAIR
GURSKI, KAREN J	STUDENT
GURSON, MD, HELEN W	ALLEGHENY
GUSTAVSON, MD, ROGER B	DAUPHIN
GUSTIN, MD, THOMAS A	ERIE
GUTEKUNST, MD, PAUL E	PHILADELPHIA
GUTHLEBEN, MD, JOHN G	ERIE
GUTHRIE, MD, DAVID A	FRANKLIN
GUTHRIE, MD, WILLIAM J	MONTGOMERY
GUTIERREZ, MD, FELIX	DAUPHIN
GUTKNECHT, MD, DAVID R	MONTOUR
GUTMANN, MD, LAURIE	ERIE
GUTTERMAN, MD, PAUL	LUZERNE
GUTTIN, MD, ENRIQUE	PHILADELPHIA
GUTTMAN, MD, MICHAEL	BUCKS
GUTTMANN, MD, GAD G	PHILADELPHIA
GUTTMANN, MD, HARVEY	MONTGOMERY
GUY, MD, MARK W	ALLEGHENY
GUYER, DO, SAMUEL	MONTGOMERY
GUZEK, MD, JOHN R	LACKAWANNA
GUZZARDO, MD, MICHAEL N	ERIE
GUZZO, MD, JOSEPH C	LEHIGH
GVOZDEN, MD, ROBERT	CAMBRIA
GWIRTZMAN, WENDY G	STUDENT

H

HAACK, MD, SUSAN M	LYCOMING
HAAG JR, MD, REED P	BRADFORD
HAAS, MD, CHARLES M	BLAIR
HAAS, MD, DAVID R	DAUPHIN
HAAS, MD, DONALD D	WESTMORELAND
HAAS, DO, GLENN E	BUCKS
HAAS, MD, KENT S	PHILADELPHIA
HAAS, DO, MYRON D	SCHUYLKILL
HAASE, MD, GUNTER R	PHILADELPHIA
HAASIS, MD, JOHN C	STUDENT
HAAZ, MD, WILLIAM S	PHILADELPHIA
HABECKER, MD, ELIZABETH T	LEBANON
HABER, MD, ARTHUR S	LUZERNE
HABER, MD, MICHELE A	PHILADELPHIA
HABER, SHERYL A	STUDENT
HABERMAN, MD, RONALD J	PHILADELPHIA
HABIG II, MD, JOSEPH A	UNION
HACKETT, MD, AYE K	ALLEGHENY
HADAR, MD, ELDAD J	PHILADELPHIA
HADDAD, MD, GEORGE R	BEAVER
HADDAD, MD, ROBERT M	MONTOUR
HADDON JR, MD, HARRY H	FRANKLIN
HADFIELD JR, MD, WILLIAM A	DELAWARE
HADLEY, MD, CAROLYN B	PHILADELPHIA
HADRA, MD, ELLINOR S	MONTGOMERY
HAEBERLE, MD, WILLIAM A	PHILADELPHIA
HAEGELE, MD, LINDA A	PHILADELPHIA
HAEGELE, DO, MARK W	CHESTER
HAEUSSNER, MD, CHARLES F	ALLEGHENY

HAFT, MD, HAROLD	PHILADELPHIA
HAGAN JR, MD, EUGENE P	PHILADELPHIA
HAGARTY, MD, JOHN J	MONTGOMERY
HAGBERG, MD, MARGARET M	ALLEGHENY
HAGBERG, MD, WILLIAM C	ALLEGHENY
HAGERTY, MD, FRED D	YORK
HAGERTY, MD, MICHAEL F	ALLEGHENY
HAGES, MD, FOSTER	BEAVER
HAGEY, DO, DEBORAH A	LANCASTER
HAGGERTY, MD, ROBERT W	DELAWARE
HAGGERTY, MD, SALLY M	NORTHAMPTON
HAHM, MD, JEE HO	PHILADELPHIA
HAHN, MD, ADAM W	ALLEGHENY
HAHN, GREGORY V	STUDENT
HAHN, MD, JEANNINE R	CHESTER
HAHN, MD, JONATHAN F	UNION
HAHN, MD, KON S	LACKAWANNA
HAHN, MD, KURT R	BRADFORD
HAHN, MD, RICHARD M	WASHINGTON
HAHN, MD, THOMAS F	MONTOUR
HAIBACH, MD, RAYMOND A	ERIE
HAIDET, MD, KEITH R	DAUPHIN
HAIGHT, MD, JOEL B	CENTRE
HAILS, MD, KEVIN C	PHILADELPHIA
HAIMOWITZ, MD, DANIEL	BUCKS
HAIMOWITZ, MD, SAMUEL I	PHILADELPHIA
HAIN, MD, HOWARD L	NORTHAMPTON
HAINES, CECELIA C	STUDENT
HAIRSTON JR, MD, JOHN C	ALLEGHENY
HAKALA, BRIAN E	STUDENT
HAKALA, MD, THOMAS R	ALLEGHENY
HAKAS, MD, JOSEPH F	ALLEGHENY
HAKE, MD, JEAN H	DAUPHIN
HALBERT, MD, DAVID R	DAUPHIN
HALCOVAGE, DO, JONATHAN P	LEBANON
HALE, MD, EDWARD H	ALLEGHENY
HALE, DO, RICHARD C	BRADFORD
HALE, MD, ROBERT G	MONTGOMERY
HALE, MD, ROBERT H	BUCKS
HALE, MD, THOMAS K	SCHUYLKILL
HALE JR, MD, RAYMOND M	ADAMS
HALEN, MD, ROBERT J	ALLEGHENY
HALENDA, MD, GREGORY	ALLEGHENY
HALL, MD, BRADLEY	ALLEGHENY
HALL, MD, DANIEL A	PHILADELPHIA
HALL, MD, DAVID G	ALLEGHENY
HALL, DONALD T	STUDENT
HALL, MD, EDGAR M	CHESTER
HALL, MD, I MACDONALD	MONTGOMERY
HALL, MD, JACK R	CRAWFORD
HALL, MD, JAMES P	BLAIR
HALL, MD, JOHN H	PHILADELPHIA
HALL, KIMBERLY A	STUDENT
HALL, MD, NEAL E	MONTGOMERY
HALL, MD, ROBERT H	STUDENT
HALL, MD, ROBERT L	CENTRE
HALL, MD, ROBERT L	DELAWARE
HALL, MD, VIRGINIA E	DAUPHIN
HALL II, MD, ROBERT F	CUMBERLAND
HALL JR, MD, JOHN H	WASHINGTON
HALLAHAN, MD, WILLIAM F	LEBANON
HALLERMEIER JR, MD, ROBERT G	DELAWARE
HALLETT, MD, JOSEPH W	PHILADELPHIA
HALLMARK, MD, KAREN H	ALLEGHENY
HALLOCK, MD, GEOFFREY	LEHIGH
HALLOCK, MD, MARGARET E	DAUPHIN
HALLOCK, MD, RICHARD H	DAUPHIN
HALMI, MD, BILL H	MONTGOMERY
HALPERIN, MD, MEYER A	MONROE
HALPERN, MD, BARRY R	PHILADELPHIA
HALPERN, MD, BARTON L	LANCASTER
HALPERN, MD, JANIS S	BUCKS
HAM, MD, JAMES W	VENANGO
HAM, MD, TONG H	MERCER
HAMADANI, MD, HOUSHANG G	LEHIGH
HAMANN, MD, JOSE G	PHILADELPHIA
HAMATY, MD, RONALD M	CAMBRIA
HAMBURG, MD, ALLEN E	MONTGOMERY
HAMDANI, MD, RAZA S	ALLEGHENY
HAMEED, MD, SHAHID	BRADFORD
HAMIDI, MD, JAFAR A	MCKEAN
HAMILTON, CLIO A	STUDENT
HAMILTON, MD, GERALDINE E	DELAWARE
HAMILTON, MD, RALPH W	PHILADELPHIA
HAMILTON, MD, ROBERT W	ALLEGHENY
HAMILTON, MD, ROBERT W	DAUPHIN
HAMILTON, MD, THOMAS E	MONTGOMERY
HAMILTON, MD, VIRGINIA M	MONTGOMERY
HAMILTON, MD, WILLIAM C	PHILADELPHIA
HAMILTON, MD, WILLIAM L	PHILADELPHIA
HAMM, MD, CHARLES R	ALLEGHENY
HAMM, MD, GLENN G	VENANGO
HAMM, MD, WILLIAM G	LYCOMING
HAMME, MD, ELMER G	YORK
HAMMELL, MD, EUGENE J	ALLEGHENY
HAMMER, MD, WILLIAM J	MONTGOMERY
HAMMETT, MD, JAMES H	ADAMS
HAMMOND, MD, CHARLES P	LANCASTER
HAMMOND III, MD, N LEROY	MONTGOMERY
HAMOY, MD, ALICE G	LYCOMING
HAMOY, MD, GEORGE L	LYCOMING
HAMPE, MD, WARREN W	MONTGOMERY
HAMPEL, MD, AVRAHAM	PHILADELPHIA
HAMPSEY, MD, JOHN A	NORTHAMPTON
HAMPTON, MD, JANET A	PHILADELPHIA
HAMPTON, MD, LOUIS J	YORK
HAMSHER, MD, JAMES R	DAUPHIN
HAMZAVI, MD, SIAMAK	LACKAWANNA
HAN, MD, AARON C	PHILADELPHIA
HAN, MD, DALSOO	ALLEGHENY
HAN, MD, PAUL K J	ALLEGHENY
HAN, MD, SAMUEL I	BUTLER
HAN, MD, SUM K	ALLEGHENY
HAN, MD, SUN TAK	LACKAWANNA
HAN, WON K	STUDENT
HAN, MD, YOONG O	ALLEGHENY
HANAU, MD, CHERYL A	PHILADELPHIA
HANBY JR, MD, W FORWOOD E	MONTGOMERY
HANCHETT, MD, JAMES E	ALLEGHENY
HANCOCK, MD, REGINALD A	ALLEGHENY
HAND, MD, ELLEN P	PHILADELPHIA
HAND, MD, ROY H	MONTGOMERY
HANDELSMAN, MD, GORDON L	ALLEGHENY
HANDELSMAN, MD, OLIVER	ALLEGHENY
HANDFORD, MD, H ALLEN	DAUPHIN
HANDLER, MD, HARLAN B	ALLEGHENY
HANDLER, MD, IRA S	BUTLER
HANDLER, MD, STEVEN D	PHILADELPHIA
HANES, MARYANN	STUDENT
HANES, MD, ROBERT B	DELAWARE
HANGEN, MD, NORMAN M	BERKS
HANHAUSEN JR, MD, EDWARD H	MONTGOMERY
HANISEK, MD, WILLIAM F	NORTHAMPTON
HANJANI, MD, PARVIZ	PHILADELPHIA
HANKEY, MD, JOHN C	ALLEGHENY
HANKINS, MD, ALTHEA	PHILADELPHIA
HANKS, MD, GERALD E	PHILADELPHIA
HANLON, MD, JAMES T	ALLEGHENY
HANLON, MD, PAUL A	LUZERNE
HANLON, MD, THOMAS W	PHILADELPHIA
HANNA, MD, ANTONIOUS H	WESTMORELAND
HANNA, MD, DWIGHT C	ALLEGHENY
HANNA, MD, EZZAT A	BERKS
HANNA, MD, HERBERT L	INDIANA
HANNA, MD, ROBERT H	CHESTER
HANNA, MD, SALAH G	WESTMORELAND
HANNA, MD, TONY A	BERKS
HANNA, MD, WAFA S	BERKS
HANNEKEN, MD, JANE R	CRAWFORD
HANNO, MD, PHILIP M	PHILADELPHIA
HANNUM, MD, CHRISTOPHER F	PHILADELPHIA
HANNUSH, MD, SADEER B	BUCKS
HANRAHAN, MD, JAMES B	ALLEGHENY
HANSEN, MD, CARL A	BUCKS
HANSEN, HILARY A	STUDENT
HANSPAL, MD, NAVJOT S	CHESTER
HANSPAL, MD, REENA K	CHESTER
HANSROTE, MD, LOUIS W	LEHIGH
HANZEL, MD, GEORGE D	CAMBRIA
HAPPEL, MD, JOHN L	ALLEGHENY
HAPPEL JR, MD, JOHN L	ALLEGHENY
HARAD, MD, FREDERIC T	PHILADELPHIA
HARADA, MD, WILLIAM A	NORTHAMPTON
HARADIN, MD, ANTHONY R	ALLEGHENY
HARALDSTED, MD, K ALEXANDER	LEHIGH
HARASYM, MD, E LAWRENCE	COLUMBIA
HARASYM, MD, EUGENE D	LACKAWANNA
HARBACH, MD, HARRISON F	ADAMS
HARBERGER, MD, JAMES H	YORK
HARCHELROAD JR, MD, FRED P	ALLEGHENY
HARDAWAY, MD, ALFRED E	LYCOMING
HARDEE-CUTHBERT, MD, KAY	MONTGOMERY
HARDEN III, MD, WESLEY R	YORK
HARDER, MD, STEVEN M	LYCOMING
HARDIN, MD, M JENNIFER	PHILADELPHIA
HARDING, MD, ROBERT L	DAUPHIN
HARDY, MD, CHARLES A	BUCKS
HARDY, MD, HEIDRUN D	ERIE
HARDY, MD, JOHN C	LEBANON
HARE, MD, JEFFREY D	NORTHAMPTON
HARE, MD, JEFFREY L	PHILADELPHIA
HAREN, MD, WILLIAM E	FRANKLIN
HARGLEROAD II, MD, JOHN A	CENTRE
HARGRAVE, MD, HUGH J	LANCASTER
HARGROVE III, MD, WALTER C	PHILADELPHIA
HARIKA, MD, JOPINDAR P	ALLEGHENY
HARINSTEIN, MD, DAVID A	ALLEGHENY
HARKANYI, MD, ZOLTAN	PHILADELPHIA
HARKAVY, MD, SANDRA E	DELAWARE
HARKER, MD, RICHARD C	LANCASTER
HARKER, EXEC SEC, MARJORIE E	BLAIR
HARKINS, MD, HERBERT P	PHILADELPHIA
HARKINS, MD, PATRICIA M	ALLEGHENY
HARKINS, MD, ROBERT S	SCHUYLKILL
HARKNESS, MD, MICHAEL J	CHESTER
HARLAN, MD, WILLIAM K	NORTHAMPTON
HARLESS, MD, JAMES M	ALLEGHENY
HARLEY, MD, BARBARA M	MONTGOMERY
HARLEY, MD, JOHN B	CAMBRIA
HARLIN, MD, STEPHEN L	PHILADELPHIA
HARM JR, MD, KENNETH R	DAUPHIN
HARMANCI, MD, M CEM	MIFFLIN/JUN
HARMATZ, MD, ALEXANDER J	PHILADELPHIA
HARMON, MD, ELI S	MONTGOMERY
HARMON-WEISS, MD, SANDRA	MONTGOMERY
HARNED, MD, E MICHAEL	PHILADELPHIA
HARNER, MD, CHRISTOPHER D	ALLEGHENY
HARNER, MD, JEFFREY D	YORK
HARNISH, MD, DAVID M	LANCASTER
HARPER, MD, JOHN B	MONTGOMERY
HARPER, MD, JOHN J	ALLEGHENY
HARPER, MD, STEVEN G	MONTGOMERY
HARR, DENISE F	STUDENT
HARR, MD, DOUGLAS P	BUCKS
HARRER JR, MD, WILLIAM J	MERCER
HARRIGER, MD, MILES D	LANCASTER
HARRING, MD, MAYNARD	SCHUYLKILL
HARRINGTON, MD, THOMAS M	MONTOUR
HARRINGTON JR, ROBERT W	STUDENT
HARRIS, MD, ALBIN W	FRANKLIN
HARRIS, ANTHONY E	STUDENT
HARRIS, MD, ARTHUR D	PHILADELPHIA
HARRIS, MD, BARRY C	ALLEGHENY
HARRIS, MD, BERNADETTE G	ALLEGHENY
HARRIS, MD, BRIAN W	DAUPHIN
HARRIS, MD, DAVID T	PHILADELPHIA
HARRIS, MD, JAMES S	PHILADELPHIA
HARRIS, MD, JAMES V	ALLEGHENY
HARRIS, KATHERINE A	STUDENT
HARRIS, MD, KENNETH H	PHILADELPHIA
HARRIS, MD, KEVIN R	MONTGOMERY
HARRIS, MD, LAWRENCE K	BERKS
HARRIS, MD, LOVELL	PHILADELPHIA
HARRIS, MD, MALCOLM S	ALLEGHENY
HARRIS, MD, MERLEEN	PHILADELPHIA
HARRIS, MD, RICHARD N	ALLEGHENY
HARRIS, MD, RONALD I	LUZERNE
HARRIS, MD, ROSEMARY M	DELAWARE
HARRIS, MD, RUSSELL H	PHILADELPHIA
HARRIS, MD, STANLEY R	LEHIGH
HARRISON, MD, ANTHONY M	ALLEGHENY
HARRISON, MD, BRETT M	BUCKS
HARRISON, MD, C SCOTT	DAUPHIN
HARRISON, MD, DIANE D	BERKS
HARRISON, MD, DREW S	LEHIGH
HARRISON, MD, FRANK D	WESTMORELAND
HARRISON, MD, JAMES L	LYCOMING
HARRISON, DO, KEITH W	MONTOUR
HARRISON JR, MD, JOSEPH	MONTGOMERY
HARROP, MD, DONALD E	CHESTER
HARRY, MD, HARRIET M	CENTRE
HARSTER, MD, GERALD A	WESTMORELAND
HART, MD, ALEX D	NORTHAMPTON
HART, MD, GEORGE R	LAWRENCE
HART, MD, JAMES C	DAUPHIN
HART, MD, NEIL J	ALLEGHENY
HART, MD, PHILIP L	FAYETTE
HART, DO, WILLIAM J	DELAWARE
HART JR, RICHARD B	STUDENT
HARTENBAUM, MD, DAVID	BUCKS
HARTENBAUM, MD, NATALIE T	BUCKS
HARTER, SCOTT C	STUDENT
HARTLE, MD, JOHN E	BEDFORD
HARTLEY, MD, PAUL A	FAYETTE
HARTMAN, MD, CHARLES E	YORK
HARTMAN, MD, DANIEL G	MONTGOMERY
HARTMAN, MD, DENISE L	MONTGOMERY
HARTMAN, MD, DOROTHY I S	LEHIGH
HARTMAN, MD, H KING	WESTMORELAND
HARTMAN, MD, OWEN W	FRANKLIN
HARTMAN, DO, STUART A	LEBANON
HARTMAN, MD, WILLIAM F	LANCASTER
HARTMAN II, MD, SAMUEL A	LEBANON
HARTMAN JR, MD, H KING	ALLEGHENY
HARTMANN, MD, DAVID B	ALLEGHENY
HARTNETT, MD, ROBERT W	CAMBRIA
HARTNETT, WILLIAM J	STUDENT
HARTSELL, THERESA L	STUDENT
HARTSOCK, MD, ROBERT J	ALLEGHENY
HARTZ, MD, LEO M	LYCOMING
HARTZ, MD, WILLIAM H	PHILADELPHIA
HARTZ-SOLOFF, MD, CYNTHIA H	ALLEGHENY
HARTZELL, MD, DAVID L	CUMBERLAND
HARTZELL JR, MD, GEORGE W	LEHIGH
HARVEY, DO, CHARLES J	BLAIR
HARVEY, MD, EDITH E	PHILADELPHIA
HARVEY, MD, GREGORY D	DELAWARE
HARVEY, MD, JAMES S	CENTRE
HARVEY, MD, KENNETH L	LEHIGH
HARVEY, ROBERT T	STUDENT
HARVEY, MD, WILLIAM D	CLEARFIELD
HARVEY, MD, WILLIAM J	ALLEGHENY
HARVEY JR, MD, BENSON	LEBANON
HARWICK, MD, JEAN C	ALLEGHENY
HARWICK, MD, JOHN D	LEHIGH
HARWICK, MD, ROBERT D	PHILADELPHIA
HASABNIS, MD, SUHAS P	BLAIR
HASAN, MD, MOHAMMAD A	SCHUYLKILL
HASBACH, MD, THOMAS J	ALLEGHENY
HASELHUHN, MD, DONALD H	DAUPHIN
HASER, MD, HEYWOOD A	ALLEGHENY
HASH JR, MD, VOLNEY W	CAMBRIA
HASHIDA, MD, YOSHIE	ALLEGHENY
HASHIMIE, MD, JAFFREY	ALLEGHENY
HASHIN, KIMBERLY A	STUDENT
HASHMI, MD, MAJID A	ALLEGHENY
HASIUK, MD, AARON S	BUCKS
HASKIN, MD, MYRA R	MONTGOMERY
HASLEY, MD, STEPHEN K	ALLEGHENY
HASS, MD, BRIAN E	PHILADELPHIA
HASSAN, MD, JOSEPH R	BERKS
HASSARD, MD, DAVID G	PHILADELPHIA
HASSEL, MD, JEFFREY L	BERKS
HASSEL, MD, MARK H	LANCASTER
HASSEL JR, MD, CARL W	LANCASTER
HASSEY, MD, JOSEPH A	PHILADELPHIA
HASSINGER, MD, KATHRYN K	YORK
HASSLACHER, MD, ELIZABETH A	PHILADELPHIA
HASSLER, MD, CARL W	BERKS
HASSOURI, MD, HASSAN	ALLEGHENY
HASTINGS, MD, LAURA A	PHILADELPHIA
HASTINGS JR, MD, LEO J	LEHIGH
HASZ, MD, RICHARD D	DAUPHIN
HATCHER, MD, KIM A	INDIANA
HATFIELD, MD, MARK E	ALLEGHENY
HATLEBERG, MD, STEVEN L	CUMBERLAND
HATTI, MD, SHIVKUMAR S	DELAWARE
HATTON, MD, DUNCAN S	DELAWARE
HATTOUM, MD, PITTAGORE	WESTMORELAND
HAUER, MD, MARLIN L	LEBANON
HAUGEN, CHRISTINE	STUDENT
HAUGER, MD, HAROLD N	WESTMORELAND
HAUGER, MD, WILLIAM D	CAMBRIA
HAUN, MD, JOHN P	LANCASTER
HAUPT, MD, DONALD N	MONTGOMERY
HAUPT, MD, GEORGE J	PHILADELPHIA
HAUPT, MD, HELEN M	PHILADELPHIA
HAUPT, MD, RICHARD M	DELAWARE
HAUS, MD, MARY M	WESTMORELAND
HAUS, MD, WILLIAM	ALLEGHENY
HAUSER, MD, JOHN R	WASHINGTON
HAUSER, MD, NORMAN	MONTGOMERY
HAUSER, MD, RAYMOND J	BERKS
HAUT, MD, MICHAEL J	PHILADELPHIA
HAUT, MD, MITCHELL	ALLEGHENY
HAVA, MD, MILOS	DELAWARE
HAVER, MD, PAUL M	BEAVER
HAVERSTICK, MD, C DAVID	DAUPHIN
HAVKO, MD, FREDERICK C	ALLEGHENY
HAVLIK, MELISSA G	STUDENT
HAVRILLA, MD, THOMAS R	ALLEGHENY
HAWK, MD, BRAINARD O	ALLEGHENY
HAWK, MD, DAVID L	YORK
HAWKE, MD, WILLIAM	BERKS
HAWKINS, MD, JAMES G	ALLEGHENY
HAWKINS, MD, ROGER A	MERCER
HAWLEY, MD, RICHARD C	SCHUYLKILL
HAWN, MD, MARGARET M	DAUPHIN
HAWRYLUK, MD, OREST	PHILADELPHIA
HAWTOF, JEFFREY E	STUDENT
HAY, MD, HAROLD S	SOMERSET
HAYASHI, MD, T TERRY	ALLEGHENY
HAYDEN, MD, JAMES B	HUNTINGDON
HAYES, MD, ANNE B	STUDENT
HAYES, MD, BRIAN L	PHILADELPHIA
HAYES, MD, JAMES C	ALLEGHENY
HAYES, MD, MERRILL B	DELAWARE
HAYES, MD, WARREN H	LYCOMING
HAYES SR, MD, PHILLIP W	PHILADELPHIA
HAYMAN, MD, HARRIS R	CHESTER
HAYMAN, MD, HARRY B	BUCKS
HAYNES, DEBORAH E	STUDENT
HAYNICZ, MD, PETER	MONROE
HAYS, MD, AMY L	ALLEGHENY
HAYS, MD, E BLAINE	CUMBERLAND
HAYTHORNTHWAITE, MD, E MARY	MONTGOMERY
HAYWARD, MD, CATHERINE Z	MONTGOMERY
HAYWOOD, MICHELE T	STUDENT
HAZLETT, MD, WILLIAM H	LUZERNE
HAZLETT JR, MD, WALTER S	WESTMORELAND
HAZZOURI, MD, MICHELE A	LACKAWANNA
HEADLEY, MD, CHAUNCEY R	WASHINGTON
HEANEY, MD, STEVEN J	CRAWFORD
HEAPS, MD, KENNETH P	YORK
HEASLETT, MD, ANN M	PHILADELPHIA
HEASLEY, MD, KENNETH H	VENANGO
HEATH, MD, F RICHARD	ALLEGHENY
HEATH, KIMBERLY A	STUDENT
HEBDA, MD, WILLIAM B	ARMSTRONG
HEBEL, JEANETTE L	STUDENT
HEBRANK, MD, GREGORY T	WESTMORELAND
HECHT, TODD E	STUDENT
HECHT, MD, WARREN B	MONTGOMERY
HECK, MD, ALBERT W	DAUPHIN
HECK, MD, HARRY J	ALLEGHENY
HECK III, MD, HARRY J	ALLEGHENY
HECKER, MD, JANENE	WASHINGTON
HECKLER, MD, FREDERICK R	ALLEGHENY
HEDRICK, MD, G WINFIELD	BUCKS
HEDRICK, MD, THOMAS A	CAMBRIA
HEERE, MD, BARBARA A	LYCOMING
HEFFELFINGER, DO, ERIC S	LUZERNE
HEFFERN, MD, JAMES E	LANCASTER
HEFFERNAN, MD, ANDREW H	LEHIGH
HEFFERNAN, MD, J MICHAEL	BERKS
HEFFLER, MD, KAREN F	PHILADELPHIA
HEFFLEY, MD, WILLIAM M	DAUPHIN
HEFFLIN, MD, BROCKTON	ALLEGHENY
HEFFLIN, MD, CHARLES M	ALLEGHENY
HEFFNER JR, MD, GEORGE W	SCHUYLKILL
HEFLIN, MD, DANIEL W	LYCOMING
HEGARTY, MD, FRANCIS A	ALLEGHENY
HEGDE, MD, SUNIL K	ALLEGHENY
HEID, MD, CHARLES E	UNION
HEIDARY, MD, GHODRATALLAH	MONTGOMERY
HEIDEN, MD, RICHARD A	BERKS
HEIDENREICH, MD, FRED P	ALLEGHENY
HEIDENREICH, MD, H VINCENT	ALLEGHENY
HEIDERSCHEIDT, BENEDICT G	STUDENT
HEIL, BRIAN V	STUDENT
HEILBRUNN, MD, STEVEN M	ALLEGHENY
HEILIGMAN, MD, NATHAN H	LEHIGH
HEILMAN, MD, J DANIEL	ALLEGHENY
HEILMANN, MD, TIMOTHY M	LAWRENCE
HEIM, MD, WILLIAM J	LACKAWANNA
HEIMBACH, MD, GEORGE Z	NORTHAMPTON
HEIMBACH, MD, JAMES A	BLAIR
HEIMER, MD, JEFFREY L	CENTRE
HEIN, MD, EDWARD W	BERKS
HEIN, MD, JEFFREY P	STUDENT
HEINBACH, MD, ROBERT A	NORTHMBRLAND
HEINBACH JR, MD, ROBERT A	LYCOMING
HEINE, DO, MARTIN K	FRANKLIN
HEINE, MD, WILLIAM I	PHILADELPHIA
HEINECKE-CHAFIN, SHERRI	STUDENT
HEINLE JR, MD, EDWARD W	BEAVER
HEINLE JR, MD, FREDERICK J	LANCASTER
HEINLY, MD, MARK N	STUDENT
HEINTZ, MD, JAMES J	LUZERNE
HEISE, MD, MICHAEL J	ALLEGHENY
HEISER, MD, MARK S	PHILADELPHIA

HEISEY, MD, JOHN C	BERKS
HEISEY, MD, ROBERT G	LEBANON
HEIST, DO, KENNETH C	PHILADELPHIA
HEISTAND, MD, LANDIS C	SCHUYLKILL
HEISTERKAMP III, MD, CHARLES A	LANCASTER
HEITMANN, DEBRA W	STUDENT
HEITZ, MD, JAMES W	PHILADELPHIA
HELFELD, DO, HOPE B	PHILADELPHIA
HELFFRICH, MD, RICHARD S	BLAIR
HELFRICH, MD, DAVID J	ALLEGHENY
HELINEK, MD, GERARD L	BERKS
HELINEK, MD, THOMAS G	BERKS
HELKOWSKI, MD, JEFFREY L	PHILADELPHIA
HELLER, MD, ALVIN G	MONTGOMERY
HELLER, MD, FREDERICKA S M	BERKS
HELLER, MD, MELVIN S	PHILADELPHIA
HELLMAN, MD, ARTHUR A	PHILADELPHIA
HELLSTROM, MD, MICHAEL D	MONTOUR
HELM, MD, ROBERT C	LANCASTER
HELM JR, MD, JOHN D	LANCASTER
HELMICK, MD, NATHANIEL D	MONROE
HELMICK, MD, WAYNE W	BEAVER
HELSING, MD, WALTER J	BEAVER
HELWIG JR, MD, JOHN	PHILADELPHIA
HELY, MD, DANIEL P	CUMBERLAND
HELZNER, MD, EILEEN C	BUCKS
HEMLER, MD, PAUL M	DAUPHIN
HEMLEY, MD, SUSAN R	NORTHAMPTON
HEMMERLY, MD, WILLIAM C	NORTHAMPTON
HEMPHILL, MD, RICHARD W	ALLEGHENY
HENCK, MD, MARK E	MONTGOMERY
HENDERSON, ELIZABETH T	STUDENT
HENDERSON, MD, K WAYNE	LYCOMING
HENDERSON, MD, ROBERT E	LAWRENCE
HENDLER, MD, BARRY H	PHILADELPHIA
HENDREN, MD, WILLIAM G	PHILADELPHIA
HENDRICKS, MD, ROBERT T	CRAWFORD
HENDRICKS, STEPHANIE L	STUDENT
HENDRICKS JR, MD, GILBERT L	CENTRE
HENDRICKS JR, MD, WILLIAM C	ERIE
HENDRICKSON, MD, CLIFFORD D	DAUPHIN
HENDRICKSON, MD, DONALD C	FRANKLIN
HENDRICKSON, MD, STEVEN C	PHILADELPHIA
HENDRIX, MD, ROBERT A	PHILADELPHIA
HENDRY, MD, STANLEY G	ALLEGHENY
HENDRZAK, ANDREA J	STUDENT
HENIEN, MD, SAMIA R	DELAWARE
HENNESSEY, MD, DAVID H	ALLEGHENY
HENNESSEY, MD, JOSEPH F	MONTGOMERY
HENNESSEY, MD, MICHAEL S	MIFFLIN/JUNI
HENNESSY, TIMOTHY J	STUDENT
HENNIG JR, DO, RICHARD W	PHILADELPHIA
HENNIGAN, SHAWN P	STUDENT
HENNING III, MD, GEORGE F	SUSQUEHANNA
HENNINGER, MD, WILLIAM H	BERKS
HENNON, MD, DON L	ALLEGHENY
HENNON, KIMBERLY A	STUDENT
HENRICKS, MD, CAROL L	PHILADELPHIA
HENRIKSEN, MD, DANIEL S	YORK
HENRIKSEN, MD, SUSAN A	YORK
HENRIQUES, MD, ERROL D	CAMBRIA
HENRIQUEZ, MD, JACK A	LEHIGH
HENRIQUEZ, MD, LILIANA C	LEHIGH
HENRY, MD, LELAND T	ARMSTRONG
HENRY, MD, MARK R	STUDENT
HENRY, MD, SCOTT P	ERIE
HENRY, MD, SHELDON D	MONTOUR
HENRY, MD, STEPHEN J	DELAWARE
HENRY, MD, WALTER J	MCKEAN
HENRY JR, MD, EDGAR S	ALLEGHENY
HENRY JR, MD, LELAND T	ALLEGHENY
HENSCHEL, KENNETH A	STUDENT
HENSLEY, MD, FREDERICK A	DAUPHIN
HENTOSH, MD, JOHN P	LEHIGH
HEPLER-SMITH, MD, MICHAEL	ALLEGHENY
HEPNER JR, MD, THOMAS A	MONTOUR
HEPPNER, MD, BRADLEY T	ALLEGHENY
HEPPNER, MD, RICHARD L	ALLEGHENY
HERALD, MD, GEOFFREY R	BEAVER
HERB, DO, RONALD K	BERKS
HERBERT, DO, REX A	DAUPHIN
HERBERT, MD, VICKI L	ALLEGHENY
HERBERT, DO, WILLIAM J	MERCER
HERBICK, MD, WILLIAM T	CAMBRIA
HERBISON, MD, GERALD J	PHILADELPHIA
HERBST, MD, BERNADETTE A	PHILADELPHIA
HERBST, MD, CHARLES G	ERIE
HERCEG, MD, STEPHEN J	DAUPHIN
HERGAN, ROBERT R	STUDENT
HERLICH, MD, ANDREW	ALLEGHENY
HERLICH, MD, THELMA L	ALLEGHENY
HERLING, MD, PATTI J	MONTGOMERY
HERMAN, MD, CARL D	PHILADELPHIA
HERMAN, MD, HAROLD	PHILADELPHIA
HERMAN, MD, JAMES M	DAUPHIN
HERMAN, MD, JAY S	ALLEGHENY
HERMAN, MD, JERRY H	PHILADELPHIA
HERMAN, MD, LEONARD Y	PHILADELPHIA
HERMAN, MD, ROMAN K	NORTHAMPTON
HERMAN, MD, RONALD J	YORK
HERMAN, MD, WALTER M	PHILADELPHIA
HERMANN, MD, CHRISTOPHER P	BUCKS
HERMANN, MD, MARY E	COLUMBIA
HERMANOVICH JR, MD, JOHN	BERKS
HERMANY, DO, DEBRA K	SCHUYLKILL
HERMANY, MD, PAUL R	BUCKS
HERNANDEZ, MD, ENRIQUE	PHILADELPHIA
HERNANDEZ, MARISOL	STUDENT
HERNANDEZ, MD, WILBERT E	LUZERNE
HERNANDEZ, MD, ZAIDA	DELAWARE
HERNDON, MD, JAMES H	ALLEGHENY
HERNZ, MD, WILLIAM J	CHESTER
HEROLD, MD, SANFORD L	PHILADELPHIA
HEROLD JR, MD, CRESTON C	DAUPHIN
HEROMIN, MD, THOMAS J	NORTHUMBERLAND
HERR, SANDRA M	STUDENT
HERRERA, MD, ANIBAL F	DELAWARE
HERRERO, MD, CARMELO	PHILADELPHIA
HERRICK, MD, WAYNE C	YORK
HERRING, MD, ALLEN B	PHILADELPHIA
HERRING, MD, CHRISTINA S	PHILADELPHIA
HERRING, GARY A	STUDENT
HERRING, GIOLA M	STUDENT
HERRING, MD, M NOREEN	PHILADELPHIA
HERRING, MD, WILLIAM	PHILADELPHIA
HERRINGTON, MD, PAMELA J	ERIE
HERROLD, MD, LEWIS C	YORK
HERROLD, MD, WARREN C	YORK
HERSCHAFT, MD, RICHARD J	LANCASTER
HERSHENSON, MD, LEE M	ALLEGHENY
HERSHEY, MD, RICHARD E	ALLEGHENY
HERSHLINE, MD, ROGER K	ALLEGHENY
HERSHOCK, MD, BRUCE A	WESTMORELAND
HERSHOCK, DIANE M	STUDENT
HERSPERGER, MD, WEBB S	CUMBERLAND
HERTLE, MD, RICHARD W	PHILADELPHIA
HERTZ, MD, BARRY C	CHESTER
HERTZ, MD, CHARLES S	LEHIGH
HERTZ, MD, JONATHAN	LEHIGH
HERTZOG, MD, JAMES E	ALLEGHENY
HERZEL JR, MD, FRANK B	DAUPHIN
HESKEL, MD, MILTON M	PHILADELPHIA
HESS, MD, EDWARD R	TIOGA
HESS, MD, FLOYD M	NORTHAMPTON
HESS, MD, IVAN W	MONTGOMERY
HESS, MD, J CLAIR	LANCASTER
HESS, MD, JOSEPH B	LANCASTER
HESS, MD, PAUL G	LANCASTER
HESS, PHILIP A	STUDENT
HESS, PHILIP E	STUDENT
HESS, DO, RUSSELL C	YORK
HESS, MD, STEVEN G	PHILADELPHIA
HESS, SUSAN K	STUDENT
HESS, MD, WILLIAM F	MONTOUR
HESSEN, MD, MARGARET T	DELAWARE
HESTER, CHRISTOPHER E	STUDENT
HETRICK, MD, WILLIAM D	ALLEGHENY
HETZLER, MD, NORMAN A	BEAVER
HEUERMANN, MD, ROBERT P	SCHUYLKILL
HEVEY, MATTHEW P	STUDENT
HEWIE, MD, S P	WASHINGTON
HEWLETT, MD, TODD F	DAUPHIN
HEWSON, MD, WILLIAM C	CHESTER
HEY JR, MD, E BERRY	BERKS
HEYDT, MD, STUART	MONTOUR
HEYL, MD, LOUIS W	ALLEGHENY
HEYL JR, MD, FRANK E	FAYETTE
HEYMACH III, MD, GEORGE J	ALLEGHENY
HEYMAN, MD, DAVID C	LYCOMING
HEYRICH, MD, GEORGE P	PHILADELPHIA
HEYWOOD, MD, SUSAN E	CENTRE
HIBBERD, MD, ALAN E	DELAWARE
HIBELL, EXEC SEC, BARBARA	CLARION
HIBEN, EUGENE E	STUDENT
HICKEY, MD, ANDREW E	YORK
HICKS, MD, EDWARD L	PHILADELPHIA
HIDALGO, MD, HORACIO A	BUCKS
HIDALGO JR, MD, HORACIO A	BUCKS
HIEHLE, MD, J FREDERICK	BERKS
HIEHLE JR, MD, JOHN F	PHILADELPHIA
HIGGINS, MD, DAVID E	BLAIR
HIGGINS, DO, KENNETH R	YORK
HIGGINS, MD, NANCY C	PHILADELPHIA
HIGGINS, MD, YING L	PHILADELPHIA
HIGH, MD, BERTRAND J	BERKS
HIGHBLOOM, MD, RICHARD Y	PHILADELPHIA
HIGHTOWER, MD, MARTIN C	BUCKS
HIJAZI, MD, SAADEDDINE A	LACKAWANNA
HILAL, MD, ELIAS Y	ALLEGHENY
HILBERG, MD, ROBERT W	ALLEGHENY
HILDEBRAND, MD, LYNNE M	DELAWARE
HILDEBRANDT, MD, CARL A	ALLEGHENY
HILEMAN, MD, JAMES D	ERIE
HILES, MD, DAVID A	ALLEGHENY
HILL, MD, CYNTHIA A	PHILADELPHIA
HILL, MD, DANIEL E	LYCOMING
HILL, MD, E MERTON	LEHIGH
HILL, MD, EDWARD B	CAMBRIA
HILL, MD, JOHN B	ALLEGHENY
HILL, MD, ROBERT J	BLAIR
HILLER JR, MD, WALTER W	ALLEGHENY
HILLS, MD, EVERETT C	DELAWARE
HILLS, JAMES R	STUDENT
HILLYER, MD, PETER N	CHESTER
HILTON, MD, ALEXANDER E	ALLEGHENY
HIMELFARB, MD, HILLARD M	FRANKLIN
HIMELSTEIN, MD, BRUCE P	PHILADELPHIA
HIMES JR, MD, RALPH F	BLAIR
HIMMELREICH III, MD, LESTER L	CUMBERLAND
HIMMELSTEIN, MD, EUGENE	DELAWARE
HIMMELSTEIN, MD, FRED R	BERKS
HIMOT, MD, LINDA J	ALLEGHENY
HINCHBERGER, MD, PAUL A	BUTLER
HINCHLIFFE, MD, JOSEPH G	ALLEGHENY
HINDI, MD, MUSA A	LUZERNE
HINEMAN, MD, MARQUIS W	BEAVER
HINERMAN, RACHEL S	STUDENT
HINES, MD, JANET M	ALLEGHENY
HINES, MD, RODERICK E	LANCASTER
HINKENS, MD, GEORGE F	ALLEGHENY
HINKLE, DO, RICHARD S	COLUMBIA
HINSMAN JR, MD, JOHN A	BRADFORD
HINSON, MD, GRETCHEN	PHILADELPHIA
HINTERBERGER, MD, JOSEPH W	LANCASTER
HIPOLITO JR, MD, EMMANUEL F	MCKEAN
HIPP, MD, THOMAS J	BUCKS
HIPPLE, MD, RANDALL F	LYCOMING
HIPPS, MD, JOHN G	TIOGA
HIRSCH, MD, BARRY E	ALLEGHENY
HIRSCH, MD, BERNARD	BEAVER
HIRSCH, MD, IRVIN H	PHILADELPHIA
HIRSCH, MD, JOSHUA A	PHILADELPHIA
HIRSCH, MD, MICHAEL A	MONTGOMERY
HIRSCH, MD, STANLEY A	ALLEGHENY
HIRSCH, MD, STUART E	BUCKS
HIRSCH, MD, WILLIAM P	CAMBRIA
HIRSH, MD, BERNARD C	PHILADELPHIA
HIRSH, MD, LEONARD F	DELAWARE
HIRSH, MD, MARC A	YORK
HIRSH, MD, ROBERT A	PHILADELPHIA
HIRSH, MD, S JAY	DELAWARE
HIRSHBERG, MD, STEVEN J	PHILADELPHIA
HIRTH, MD, JOANN S	PHILADELPHIA
HISRICH, MD, GLENN D	WASHINGTON
HISSOM JR, MD, BYRON R	BLAIR
HITCHCOCK, MD, JOHN	ALLEGHENY
HITCHNER, MD, LEWIS C	DELAWARE
HITRYS, DO, ALBIE	MERCER
HLAVAC, MD, CHERYL A	CHESTER
HLAVAC, MARK A	STUDENT
HNELESKI JR, MD, IGNATIUS S	CHESTER
HO, MD, ALLEN C	PHILADELPHIA
HO, MD, CLEMENT T	YORK
HO, JACQUELINE	STUDENT
HO, PAUL C	STUDENT
HO, MD, SZE-KEY	ERIE
HO, MD, THONG V	PHILADELPHIA
HO, MD, YEE C	ALLEGHENY
HOBART, MD, JOHN H	NORTHAMPTON
HOBBS, MD, JAN D	UNION
HOBBS, MD, JOSEPH H	SCHUYLKILL
HOBBS, MD, ROBERT E	SCHUYLKILL
HOBBS, MD, THOMAS R	DAUPHIN
HOBERMAN, MD, EDWARD	CLINTON
HOBERMAN, MD, MAURY	CHESTER
HOBSON, MD, SCOTT R	ALLEGHENY
HOCA, MD, RENATA D	ALLEGHENY
HOCH, MD, BRADLEY R	ADAMS
HOCH, MD, CARL W	ALLEGHENY
HOCH, MD, JOHN J	NORTHAMPTON
HOCH, MD, WILLIS S	BERKS
HOCHBERG, MD, ROBERT D	PHILADELPHIA
HOCHMAN, MD, RODNEY F	BRADFORD
HOCHREITER, DO, GEORGE C	ERIE
HOCKENBERRY, SHERRY L	STUDENT
HOCKFIELD, MD, HAL S	MONTGOMERY
HODA, MD, TAHIRUL	BRADFORD
HODES, MD, PHILIP J	PHILADELPHIA
HODESS, MD, ARTHUR S	CHESTER
HODGE, MD, ARTHUR J	DAUPHIN
HODGES, MD, JOHN H	PHILADELPHIA
HODGSON, MD, JOHN P	ALLEGHENY
HOELLEIN, MD, DEBORAH E	PHILADELPHIA
HOERNER, MD, GEORGE H	YORK
HOERNER, MD, RALPH W	PHILADELPHIA
HOESSLY, MD, MICHEL C	MONTGOMERY
HOEY, DO, STEPHEN E	DELAWARE
HOFF, MD, WILLIAM S	LEHIGH
HOFFMAN, MD, ARTHUR D	LEHIGH
HOFFMAN, MD, BRUCE I	PHILADELPHIA
HOFFMAN, MD, CARL J	MONTGOMERY
HOFFMAN, MD, CHAUNCEY	CAMBRIA
HOFFMAN, MD, DAVID A	BERKS
HOFFMAN, MD, DAVID E	NORTHAMPTON
HOFFMAN, MD, DAVID J	YORK
HOFFMAN, MD, ERIKA L	ALLEGHENY
HOFFMAN, MD, FRANKLIN D	ALLEGHENY
HOFFMAN, MD, GILBERT M	NORTHAMPTON
HOFFMAN, MD, GLENN H	LEBANON
HOFFMAN, MD, HOLLY C	CUMBERLAND
HOFFMAN, MD, HOWARD L	FRANKLIN
HOFFMAN, MD, J DAVID	PHILADELPHIA
HOFFMAN, MD, J LYNN	CUMBERLAND
HOFFMAN, MD, JAMES P	MONTGOMERY
HOFFMAN, MD, JOHN E	NORTHAMPTON
HOFFMAN, MD, JOHN P	PHILADELPHIA
HOFFMAN, DO, MARC E	ALLEGHENY
HOFFMAN, MD, NEIL A	BERKS
HOFFMAN, MD, SALEE L	BLAIR
HOFFMAN, MD, WILLIAM J	WESTMORELAND
HOFFMAN, MD, WILLIAM W	LEHIGH
HOFFMAN JR, MD, GEORGE L	PHILADELPHIA
HOFFMAN JR, MD, RICHARD R	LEBANON
HOFFMAN-TERRY, MD, MARGARET L	LEHIGH
HOFFMANN, MD, RON	MONTGOMERY
HOFFMEIER, MD, CHARLES L	PHILADELPHIA
HOFMAN, MD, WALTER I	MONTGOMERY
HOFMANN, MD, DOUGLAS J	YORK
HOFMANN, MD, JAMES W	YORK
HOFMANN, MD, MARY T	PHILADELPHIA
HOFMEISTER, JOSEPH K	STUDENT
HOFSTETTER, MD, ALEXANDER M	ALLEGHENY
HOFSTETTER, MD, MARK	ALLEGHENY
HOFSTROM, MD, GLEN T	LYCOMING
HOGAN, MD, W MICHAEL	MONTGOMERY
HOGAN, WILLIAM R	STUDENT
HOGG, MD, JEFFERY P	ALLEGHENY
HOHING, MD, CHARLES C	ALLEGHENY
HOHMANN, MD, THOMAS C	ALLEGHENY
HOKE JR, MD, HUGH H	LANCASTER
HOLDEN, MD, JOHN P	PHILADELPHIA
HOLDEN, MD, LYNNE M	MONTGOMERY
HOLDER, MD, ARTHUR J	LANCASTER
HOLENCIK, DO, MARK P	DAUPHIN
HOLFELNER, MD, EDWARD D	PHILADELPHIA
HOLL, MD, PAUL F	ALLEGHENY
HOLLA, MD, P SHRIPATHI	LACKAWANNA
HOLLAND, MD, CLARENCE A	LEHIGH
HOLLAND, MD, EDWARD F	YORK
HOLLAND, MD, MARK P	SCHUYLKILL
HOLLAND, MD, SANFORD J	LACKAWANNA
HOLLAND JR, MD, CLARENCE A	LEHIGH
HOLLAND-HULL, MD, NORMAN E	BUCKS
HOLLANDER, ALEXIS C	STUDENT
HOLLANDER, MD, BENTLEY A	PHILADELPHIA
HOLLANDER, MD, GEORGE	PHILADELPHIA
HOLLANDER, MD, IRWIN J	BUCKS
HOLLANDER, MD, JOSEPH L	PHILADELPHIA
HOLLEN, MD, ROBERT A	CUMBERLAND
HOLLENBAUGH, MD, FONDA J	ALLEGHENY
HOLLERAN, MD, BERNARD L	LUZERNE
HOLLIMAN, MD, CECIL J	DAUPHIN
HOLLINGSWORTH, MD, KENNETH E	PHILADELPHIA
HOLLOWAY, G BRIAN	STUDENT
HOLLOWAY, KATHLEEN A	STUDENT
HOLM, MD, ERIC K	BERKS
HOLM, MD, WILLIAM W	MONTGOMERY
HOLMAN, DAWN M	STUDENT
HOLMAN, MD, INGRID A	ALLEGHENY
HOLMBERG, MD, DONALD E	MONTGOMERY
HOLMES, MD, JOHN J	LACKAWANNA
HOLMS, DO, BARRY C	DELAWARE
HOLROYDE, MD, CHRISTOPHER P	CHESTER
HOLSINGER, MD, DAVID F	CAMBRIA
HOLST, MD, HAZEL I	DELAWARE
HOLSTEIN, MD, JAMES J	DELAWARE
HOLT, MD, ALLEN H	MERCER
HOLT, DO, SARAH W	LANCASTER
HOLTZER, MD, KARL W	ALLEGHENY
HOLTZMAN, MD, HENRY B	BUCKS
HOLZINGER, MD, ELMER J	ALLEGHENY
HOMAN, MD, MAL R	BRADFORD
HOMER, MD, JOHN W	BRADFORD
HONEBRINK, MD, ANN L	PHILADELPHIA
HONET, MD, JAMES E	PHILADELPHIA
HONG, MD, KAB S	CUMBERLAND
HONG, MD, KEUMSOON	PHILADELPHIA
HONG, MD, SOO W	LYCOMING
HONG, MD, SUNG H	BEAVER
HONG, YUHOE G	STUDENT
HONGBARCO, MD, PABLO	ALLEGHENY
HONICK, DANA L	STUDENT
HONIGMAN, MD, FREDERIC H	PHILADELPHIA
HONKALA, MD, TIMOTHY K	ALLEGHENY
HOOBLER, MD, RANDALL J	ERIE
HOOD, MD, HENRY L	MONTOUR
HOOD, MD, JOHN M	ERIE
HOOKER, HENRY C	STUDENT
HOON, MD, WILLIAM L	ALLEGHENY
HOOTMAN, MD, BARRY D	BUTLER
HOOTMAN, MD, J KENNETH	ALLEGHENY
HOOVER, MD, ALAN D	ALLEGHENY
HOOVER, MD, CARL H	LANCASTER
HOOVER, MD, DARREN L	ALLEGHENY
HOOVER, MD, DEAN S	YORK
HOOVER, MD, JUDITH A	MONTGOMERY
HOOVER, MD, PAUL M	BEAVER
HOOVER, MD, PHILIP A	YORK
HOOVER II, MD, BENJAMIN A	YORK
HOOVLER, MD, PHILIP W	BLAIR
HOPE, MD, ALEXANDRA M	ALLEGHENY
HOPKINS, MD, F THOMAS	MONTGOMERY
HOPKINS, TIM B	STUDENT
HOPPENFELD, BRAD M	STUDENT
HOPPER, MD, BRUCE D	MONTGOMERY
HORAN, MD, CHARLES A	PHILADELPHIA
HORAN, MD, GERALD W	PHILADELPHIA
HORANGIC, NICHOLAS J	STUDENT
HORCHAK, MD, ALEX M	BEAVER
HORCHOS, MD, DONALD D	LACKAWANNA
HORMAN, MD, MARC J	MONTGOMERY
HORMELL, MD, JOHNSON G	BLAIR
HORN, MD, RICHARD H	ALLEGHENY
HORN, MD, THOMAS L	ALLEGHENY
HORN III, MD, FRANK W	YORK
HORNBERGER, MD, KEVIN F	PHILADELPHIA
HORNER, MD, TIMOTHY H	WASHINGTON
HORNER JR, MD, DANIEL W	MONTGOMERY
HORNICEK SR, MD, FRANCIS J	ALLEGHENY
HORNICK, MD, ANTHONY M	LANCASTER
HORNSTEIN, MD, LUCY E	CHESTER
HOROWITZ, MD, CAROLYN J	PHILADELPHIA
HOROWITZ, DO, GARY R	PHILADELPHIA
HOROWITZ, MD, GLENN D	PHILADELPHIA
HORROW, MD, JAN C	PHILADELPHIA
HORSLEY, MD, ROSS A	MCKEAN
HORST, MD, ELMER L	BERKS
HORSTMAN, MD, ROSEMARY	PHILADELPHIA
HORT, KURTIS R	STUDENT
HORTH, MD, DANIEL J	WASHINGTON
HORTH, ROBERT M	STUDENT
HORTON, MD, DAVID J	BERKS
HORTON, MD, JOSEPH A	ALLEGHENY
HORTON, PENNE J	STUDENT
HORVATH, MD, DAVID A	ALLEGHENY
HORWIN, MD, SAMUEL	CAMBRIA
HORWITZ, MD, BRETT R	MONTGOMERY
HORWITZ, MD, MILTON R	BUCKS
HOSFELD, MD, S MARJORIE	CHESTER

HOSPODAR, MD, MARK E	ALLEGHENY
HOSSAIN, MD, AYESHA	WESTMORELAND
HOST, MD, WILLIAM R	WYOMING
HOSTEN, MD, EDWARD B	PHILADELPHIA
HOSTETTER, MD, ABRAM M	LEBANON
HOTMER, MD, DIANNE D	CHESTER
HOTTENSTEIN, MD, DANIEL W	DAUPHIN
HOTTENSTEIN, MD, JONATHAN E	ALLEGHENY
HOU, MD, CHING W	ERIE
HOUGAARD, MD, JOHN P	BUCKS
HOUGH, MD, DOUGLAS R	BUCKS
HOUGH, MD, RODNEY K	CUMBERLAND
HOUIDES, MD, ATHANASIOS C	LEHIGH
HOUSER, MD, JAMES J	VENANGO
HOUSER, STEPHEN A	STUDENT
HOUSER, EXEC SEC, JUNE L	CLINTON
HOUSHMAND, MD, CYRUS	CARBON
HOUSMAN, MD, JOHN H	LANCASTER
HOUSTON, MD, JOHN B	MONTOUR
HOUSTON, MD, R ROSS	LAWRENCE
HOUSTON JR, MD, ROBERT R	LAWRENCE
HOUSTON JR, MD, WILLIAM M	PHILADELPHIA
HOVENDEN, MD, ANTHONY L	ALLEGHENY
HOWANITZ, MD, EMIL P	LUZERNE
HOWARD, MD, THOMAS K	YORK
HOWATT, JANIS L	STUDENT
HOWE, MD, FRANCIS R C	DAUPHIN
HOWE, MD, J DALE	NORTHAMPTON
HOWELL, MD, JOHN T	BUCKS
HOWELL JR, MD, DAVID D	ERIE
HOWER, MD, ROBERT D	ALLEGHENY
HOWLAND, MD, ROBERT H	ALLEGHENY
HOWSE, MD, ROBERT M	LANCASTER
HOY, DAVID S	STUDENT
HOY, MD, RICHARD K	ERIE
HOYLE, MD, J PRESTON	UNION
HOYNIAK, MD, ANN L	STUDENT
HOYSON, MD, GREGORY M	ALLEGHENY
HOYT, DO, BERNARD S	MERCER
HOYT, DO, DAVID G	MERCER
HOYT, MD, JOHN W	ALLEGHENY
HOYT, MD, RALPH C	BERKS
HOZACK, MD, WILLIAM J	PHILADELPHIA
HRATKO, MD, JOHN R	NORTHAMPTON
HRINDA, MD, JOHN G	ERIE
HRYSHKO, MD, FRANK G	ALLEGHENY
HSIEH, DENNIS S	STUDENT
HSIEH, MING-ZU J	STUDENT
HSU, GOETHE I	STUDENT
HSU, MD, SHIEN S	WASHINGTON
HSU, MD, WEI T	DELAWARE
HU, CHARLENE H	STUDENT
HU, MD, KANG-NING	ALLEGHENY
HU, MD, WEI-TZER	SCHUYLKILL
HUANG, MD, ABBY I	PHILADELPHIA
HUANG, MD, CHAU FE	LACKAWANNA
HUANG, MD, JUNG T	BRADFORD
HUBBARD, MD, RAYMOND J	BERKS
HUBER, MD, DONALD J	ALLEGHENY
HUBER, MD, KENNETH C	ALLEGHENY
HUBSHER, MD, JAY W	DELAWARE
HUDAK, MD, MARY J	YORK
HUDES, MD, DEBRA L	PHILADELPHIA
HUDOCK, MD, JUDE A	PHILADELPHIA
HUDOCK, MD, MICHAEL J	BRADFORD
HUDOCK, MD, STEPHEN A	BRADFORD
HUDOCK JR, MD, GEORGE E	LUZERNE
HUDSON, MD, HOWARD L	ERIE
HUDSON JR, MD, HOWARD E	LEHIGH
HUDZICKI, MARIE E	STUDENT
HUDZINSKI, MD, MARTIN	FRANKLIN
HUEBNER, MD, DENISE L	DELAWARE
HUFF, MD, DENISE	ALLEGHENY
HUFFARD, MD, ROBERT S	CENTRE
HUFFER, MD, DONALD H	YORK
HUFFMAN, MD, PAMELA A	PHILADELPHIA
HUFFNAGLE, MD, HENRY W	LANCASTER
HUGHES, MD, DAVID C	INDIANA
HUGHES, MD, DAVID P	LANCASTER
HUGHES, DO, ELIZABETH B	PHILADELPHIA
HUGHES, MD, GEORGE V	ALLEGHENY
HUGHES, MD, HOWARD G	MONTOUR
HUGHES, MD, JAMES M	ALLEGHENY
HUGHES, MD, JANE S	PHILADELPHIA
HUGHES, DO, PARIS D	PHILADELPHIA
HUGHES, MD, PATRICK H	ALLEGHENY
HUGHES, MD, PAUL J	LUZERNE
HUGHES, MD, SUSAN M	PHILADELPHIA
HUGHES, MD, WILLIAM	WESTMORELAND
HUGHEY, MD, JAMES R	WASHINGTON
HUGO, KRISTINE E	STUDENT
HUGO, MD, MARYANNE	ALLEGHENY
HUH, YOUNG I	STUDENT
HUHTA, MD, JAMES C	PHILADELPHIA
HULICK, MD, PETER R	LANCASTER
HULL III, MD, DONALD F	LYCOMING
HULLEY JR, MD, WILLIAM C	ALLEGHENY
HUME, MD, ERIC L	PHILADELPHIA
HUMES, MD, ALEXANDER B	ALLEGHENY
HUMES, MD, ELLEN M	MIFFLINBURG
HUMMER III, MD, CHARLES D	DELAWARE
HUMMER JR, MD, CHARLES D	DELAWARE
HUMPHREY, MS, DAVID M	PHILADELPHIA
HUMPHREY, MD, DIEGO S	PHILADELPHIA
HUMPHREYS, MD, EARL A	ALLEGHENY
HUNDLEY, MD, J WARREN	PHILADELPHIA
HUNG, MD, GREGORY L	ALLEGHENY
HUNN, MD, RICHARD H	ALLEGHENY
HUNSBERGER, MD, CHARLES L	CAMBRIA
HUNSBERGER, MD, JOSEPH L	MONTGOMERY
HUNSICKER, MD, LLEWELLYN W	MONROE
HUNSICKER, MD, ROBERT C	NORTHAMPTON
HUNT, MD, EUGENE H	BUCKS
HUNT, MD, JOSIAH A	YORK
HUNT, MD, ROBERT E	BUTLER
HUNT JR, MD, WILLIAM T	PHILADELPHIA
HUNTER, MD, CAROL A	LEHIGH
HUNTER, DEBORAH R	STUDENT
HUNTER, MD, DORIS M	ALLEGHENY
HUNTER, MD, FRANCES C	PHILADELPHIA
HUNTER, MD, GEORGE R	WESTMORELAND
HUNTER, MD, JAMES M	PHILADELPHIA
HUNTER, MD, JOHN S	BERKS
HUNTER, MD, MARVIN T	BUCKS
HUNTER, MD, ROBERT G	COLUMBIA
HUNTER, MD, ROBERT J	CENTRE
HUNTLEY, MD, ARTHUR C	PHILADELPHIA
HUNTLY, MD, MICHAEL R	BRADFORD
HUOT, MD, DAVID A	ALLEGHENY
HUREWITZ, MD, SYLVAN J	PHILADELPHIA
HURH, MD, RYON	ALLEGHENY
HURITE, MD, FRANCIS G	ALLEGHENY
HURLEY, MD, HARRY J	DELAWARE
HURLEY, MD, JOHN N	PHILADELPHIA
HURLEY II, MD, JAMES E	FRANKLIN
HURLOCK, MD, JOAN E	PHILADELPHIA
HUROWITZ, DO, MARC P	PHILADELPHIA
HURSH, MD, DALE K	LANCASTER
HURST, MD, JOHN W	BLAIR
HURST, MD, KENNETH L	LANCASTER
HURWITZ, DO, CHARLES	PHILADELPHIA
HURWITZ, MD, DENNIS J	ALLEGHENY
HURWITZ, MD, LARRY E	ALLEGHENY
HURWITZ, MARK D	STUDENT
HUSAIN, MD, AATIF M	PHILADELPHIA
HUSAIN, MD, SALEEM	PHILADELPHIA
HUSAIN, MD, ZAHID	LUZERNE
HUSAINI, MD, SYED N	ALLEGHENY
HUSKEY, MD, RICHARD E	PHILADELPHIA
HUSSAIN, BILAL R	STUDENT
HUSSAIN, MD, HAMID	BUCKS
HUSSAINI, MD, SYED R	ALLEGHENY
HUSSEY, STEPHEN A	STUDENT
HUSSON, MD, MICHAEL A	PHILADELPHIA
HUST, MD, FREDERICK S	BUTLER
HUSTED, MD, JAMES W	DELAWARE
HUSTON, MD, CHARLES C	CLARION
HUTCHINGS, MD, DIANA M	BUCKS
HUTCHINSON, MD, RITA M	PHILADELPHIA
HUTCHINSON, MD, THOMAS A	LEHIGH
HUTCHINSON III, DO, HARRY J	CHESTER
HUTCHISON, MD, JAMES C	MONTGOMERY
HUTSON, DO, JODY W	COLUMBIA
HUTT, MD, GORDON H	LANCASTER
HUTTON, MD, JOHN E	YORK
HUWE JR, MD, JOSEPH E	ALLEGHENY
HUXSTER, MD, ROBERT H	CHESTER
HWAN, MD, JUNG J	LACKAWANNA
HWANG, MD, MAISIE	ALLEGHENY
HYATT, MD, FLOYD R	ERIE
HYATT, MD, GLENN A	MONTGOMERY
HYATT, MD, ROBERT W	PHILADELPHIA
HYDE, MD, BRUCE I	ALLEGHENY
HYDOCK, NICOLE A	STUDENT
HYETT, MD, MARVIN R	PHILADELPHIA
HYKES, MD, JAMES I	MONTGOMERY
HYLAND, MD, JULIA K	BUCKS
HYLBERT JR, MD, KENNETH W	CENTRE
HYMAN, MD, DAVID S	NORTHAMPTON
HYMAN, MD, HAROLD L	PHILADELPHIA
HYMAN, MD, HERBERT L	LEHIGH
HYNES, MD, ELIZABETH T	DAUPHIN
HYNES, LISA R	STUDENT
HYZINSKI, MD, MARTIN S	LACKAWANNA

I

IALEGGIO, MD, JOHN J	NORTHAMPTON
IAMS, MD, WILLIAM B	DAUPHIN
IANCU, MD, ALBERT L	ALLEGHENY
IANNACONE, MD, WILLIAM M	PHILADELPHIA
IANNAMORELLI, MD, ANTHONY S	FAYETTE
IANNARONE, MD, LORENZ N	MONTGOMERY
IANNI, DO, BARBARA D	BUCKS
IANNI, DO, DANIEL J	BUCKS
IANNUZZI, MD, C CHARLES	ALLEGHENY
IBACH, MD, MICHAEL B	PHILADELPHIA
IBANEZ, MD, MELCHISEDEC	MCKEAN
IBARRA, MD, JOSELUIS	LANCASTER
IBRAHIM, SAMIH A	STUDENT
ICHIKAWA, MD, DIANE C L	ALLEGHENY
ICHTER, MD, JOSEPH T	LUZERNE
ICKLER, MD, JOHN L	MONTGOMERY
IDDENDEN, MD, DAVID A	PHILADELPHIA
IDICULLA, MD, ANNE A	PHILADELPHIA
IDREES, MD, MOHAMMAD	ALLEGHENY
IDUCOVICH, MD, NICHOLAS	WESTMORELAND
IERARDI, MD, RALPH P	PHILADELPHIA
IGIDBASHIAN, DO, VARTAN N	DELAWARE
IGLESIAS, MD, MANUEL	LANCASTER
IGNACIO JR, MD, GLICERIO V	CAMBRIA
IGNATIUS, MD, PAUL F	WARREN
IGNOCHECK, MD, ANTHONY R	ERIE
IGUCHI, MD, ALBERT K	CUMBERLAND
IIDA, ERIC S	STUDENT
IJELU, MD, GORDON	PHILADELPHIA
ILIAS, ELISABETH H	STUDENT
ILKHANIPOUR, KAMYAR	STUDENT
ILKHANIPOUR, MD, VALEH	ALLEGHENY
ILKHANIPOUR, MD, ZAHRA S	ALLEGHENY
ILLINGWORTH, DO, WILLIAM A	BEDFORD
ILSON, MD, BERNARD E	PHILADELPHIA
IMAGIRE, JILLIAN S	STUDENT
IMAIZUMI, MD, SHOTARO	DELAWARE
IMBER, MD, IRVING	BERKS
IMBRIGLIA JR, MD, JOSEPH E	ALLEGHENY
IMBRIGLIA SR, MD, JOSEPH E	LUZERNE
IMBROGNO, MD, MICHAEL S	LUZERNE
IMPERIALE, MD, SALVATORE M	LUZERNE
IMPINK, MD, ROBERT R	BERKS
IMUNDO, MD, TERRI A	PHILADELPHIA
INCORVATI, DO, DENNIS L	ALLEGHENY
INCORVATI, DO, ROBERT L	ALLEGHENY
INDECK, MD, MATTHEW C	MONTOUR
INDORATO, MD, LEROY S	ALLEGHENY
INGAGLIO, MD, PHILIP E	PHILADELPHIA
INGERMAN, MD, MARK J	PHILADELPHIA
INGERSOLL, MD, CHARLES J	PHILADELPHIA
INGLESE, MD, ROBERTO	BEAVER
INGRAHAM, MD, HERBERT J	MONTOUR
INGUI, MD, JOHN	PHILADELPHIA
INNERS, MD, CHARLES R	DAUPHIN
INNIS, MD, PATRICIA A	BERKS
INOUYE, MD, LISA S	ALLEGHENY
INSERRA, MD, DIANE W	ALLEGHENY
INSLEY JR, MD, MARION C	DAUPHIN
INTRIERI, MD, PETER M	VENANGO
INZERILLO, MD, JOHN J	DAUPHIN
IOBST, MD, WILLIAM F	LUZERNE
IOCONO, JOSEPH A	STUDENT
IORIO, MD, LOUIS J	MCKEAN
IQBAL, MD, NADEEM	BEAVER
IQBAL, MD, SARWAT A	PHILADELPHIA
IQBAL, SYMA	STUDENT
IQBAL, MD, ZAFAR	ALLEGHENY
IRACKI, MD, DANIEL A	ALLEGHENY
IRANI, MD, MAHAKHURSHID	NORTHAMPTON
IRANI, MD, MAHATAB	NORTHAMPTON
IRANI, MD, ROSHEN N	PHILADELPHIA
IRBY, MD, SUSAN K	ALLEGHENY
IREY JR, MD, PHILIP M	COLUMBIA
IRIZARRY, MD, CARMEN P	PHILADELPHIA
IRR JR, MD, WILLIAM G	ALLEGHENY
IRVING, MD, THOMAS H	ALLEGHENY
IRWIN, MD, JOHN T	BUCKS
IRWIN JR, MD, GLENN E	MCKEAN
ISAACS, MD, CHARLES T	DAUPHIN
ISAACS, MD, GILBERT H	ALLEGHENY
ISAACS, MD, LAWRENCE E	PHILADELPHIA
ISAACSON, MD, CINDY S	PHILADELPHIA
ISAACSON, MD, FRED M	BUCKS
ISAACSON, MD, HOWARD	PHILADELPHIA
ISARD, MD, HAROLD J	PHILADELPHIA
ISARIYAWONGSE, MD, PRAKORN	FAYETTE
ISDANER, MD, NEIL L	PHILADELPHIA
ISENBERG, MD, CHESTER L	HUNTINGDON
ISENBERG, MD, RICHARD A	PHILADELPHIA
ISHII, MASARU	STUDENT
ISHLER, MD, H RICHARD	CENTRE
ISIDRO, MD, ENRIQUE A	ERIE
ISIDRO, MD, EUGENIO G	LAWRENCE
ISLAMOFF, MD, IGOR I	CAMBRIA
ISMAEL, MD, MOHAMED M	ALLEGHENY
ISMAIL-BEIGI, MD, FARHAD	ALLEGHENY
ISRAEL, MD, HAROLD L	PHILADELPHIA
ISRAEL, MD, HOWARD A	LEHIGH
ISRAEL, MD, MICHAEL	ALLEGHENY
ITSKOWITZ, MD, ALAN L	ALLEGHENY
ITSKOWITZ, MD, HARVEY Z	PHILADELPHIA
ITZKOFF, MD, JEROME M	ALLEGHENY
IVES, CHARLENE A	STUDENT
IVINS, MD, JOSEPH L	DELAWARE
IVINS, MD, SAMUEL P	DELAWARE
IVKER, MD, MORRIS	MONTGOMERY
IVY, MD, MARY E	LANCASTER
IYENGAR, MD, PURUSHOTHAMA M	WESTMORELAND
IZZO, MD, DOMENIC C	BERKS
IZZO, MD, KENNETH L	PHILADELPHIA

J

JABBOUR, MD, NICOLAS	ALLEGHENY
JABLIN, MD, PETER M	FRANKLIN
JABLONSKI, MD, RICHARD R	ALLEGHENY
JACKEL, MD, ROY A	MONTGOMERY
JACKLINE JR, MD, JOSEPH J	ALLEGHENY
JACKSON, MD, FRANK W	DAUPHIN
JACKSON, MD, JAY R	YORK
JACKSON, MD, MELVIN L	PHILADELPHIA
JACKSON, MD, PAUL W	DELAWARE
JACKSON, MD, RAYMOND W	BEDFORD
JACKSON, MD, RICHARD D	LANCASTER
JACKSON, MD, TIMOTHY L	BEAVER
JACOB, MD, HERBERT E	ALLEGHENY
JACOB, MD, LEONARD S	PHILADELPHIA
JACOB, MD, W LINDSAY	ALLEGHENY
JACOBELLI, MD, MICHAEL C	BUCKS
JACOBIUS, MD, HENRY F	NORTHAMPTON
JACOBS, MD, CLYDE H	NORTHUMBERLAND
JACOBS, MD, DAVID	ALLEGHENY
JACOBS, MD, FRANCIS	CHESTER
JACOBS, MD, GEORGE J	ALLEGHENY
JACOBS, MD, IRVIN	LUZERNE
JACOBS, MD, JOSEPH A	PHILADELPHIA
JACOBS, MD, JOSEPH M	NORTHAMPTON
JACOBS, MD, KENNETH M	LACKAWANNA
JACOBS, MD, MARK	DELAWARE
JACOBS, MD, RICHARD R	ALLEGHENY
JACOBS, MD, ROBERT V	SOMERSET
JACOBS, MD, SAMUEL A	ALLEGHENY
JACOBS, MD, STANLEY R	PHILADELPHIA
JACOBSON, MD, HORACE H	BRADFORD
JACOBSON, MD, JAMES N	ALLEGHENY
JACOBSON, MD, KENNETH L	MONTGOMERY
JACOBSON, MD, LOUISE	LACKAWANNA
JACOBSON, MD, MARK D	ALLEGHENY
JACOBSON, MD, MARTIN A	BERKS
JACOBSTEIN, MD, JEROME G	PHILADELPHIA
JACOBUS, MD, JUDITH L	BLAIR
JACOBY, MD, RICHARD A	PHILADELPHIA
JACQUES, MD, GEORGE A	ALLEGHENY
JACQUES, MD, JANICE A D	MONTGOMERY
JADALI, MD, NASSRIN	PHILADELPHIA
JADIDI, MD, SHIRIN	NORTHAMPTON
JADITZ, DO, STEPHEN G	LACKAWANNA
JAEGER, MD, EDWARD A	DELAWARE
JAEGER, MD, ROBERT M	LEHIGH
JAEGER, MD, SCOTT H	PHILADELPHIA
JAEGER, MD, SCOTT M	ADAMS
JAFAR, MD, MOHAMMAD A	PHILADELPHIA
JAFARI, MD, NERCY	LEHIGH
JAFERI, MD, BARKAT A	BUCKS
JAFFARI, MD, MOHAMMED	PHILADELPHIA
JAFFE, MD, BERYL	PHILADELPHIA
JAFFE, MD, JOEL D	BUCKS
JAFFE, MD, JOHN S	LEHIGH
JAFFE, MD, LOUIS	MONTGOMERY
JAFFE, MD, MARVIN E	PHILADELPHIA
JAFFE, MD, STEPHEN C	PHILADELPHIA
JAFFEE, DO, LEE	PHILADELPHIA
JAGANNATH, MD, ANAND	DAUPHIN
JAHNLE, MD, RICHARD L	DELAWARE
JAHRE, MD, JEFFREY A	NORTHAMPTON
JAHROMI, MD, HEIDAR K	CHESTER
JAKAB, MD, IRENE	ALLEGHENY
JAKABOVICS, MD, EVA	BUCKS
JAKUBEK, MD, DONALD J	WESTMORELAND
JALALI, MD, SHAILEN	PHILADELPHIA
JALIL, MD, NATHANIEL S	PHILADELPHIA
JAMA, DO, ROBERT H	LACKAWANNA
JAMALI, MD, ANMAR A	DELAWARE
JAMES, DO, EDWARD E	ALLEGHENY
JAMES, MD, EDWARD K	BERKS
JAMES, MD, FRANK S	PHILADELPHIA
JAMES, MD, GEOFFREY M	DAUPHIN
JAMES, MD, JEFFREY R	BERKS
JAMES, MD, NARENDRA N	BERKS
JAMES, MD, RICHARD A	ALLEGHENY
JAMES, MD, ROBERT T	BRADFORD
JAMESON, MD, E CARLETON	LANCASTER
JAMIL, MD, QAZI A	MCKEAN
JAMISON, MD, JAMES P	ALLEGHENY
JAMNBACK, MD, LISA A	ALLEGHENY
JAMSHIDI, MD, JAVAD	BEAVER
JAN, MD, REHANA A	PHILADELPHIA
JAN, MD, RONALD S	PHILADELPHIA
JAN, MD, TAYYABA S	LACKAWANNA
JANA, MD, BARID B	WESTMORELAND
JANA, MD, DILIP K	ERIE
JANAKIRAMAN, MD, VIJAYARA G	BLAIR
JANECKA, MD, IVO P	ALLEGHENY
JANERICH, MD, ALBERT D	LUZERNE
JANESKY, MD, CINDY	LANCASTER
JANEWAY, MD, TIMOTHY	ALLEGHENY
JANG, MD, JANG-HUEI	LUZERNE
JANIAK, DO, DANIEL D	ALLEGHENY
JANICIJEVIC, MD, MILENA	ALLEGHENY
JANICIJEVIC, MD, NENAD	ALLEGHENY
JANJIGIAN, MD, EDWARD R	LUZERNE
JANNELLI, MD, ANGELA F	BUCKS
JANNELLI, MD, DOROTHY F	ALLEGHENY
JANNETTA, MD, PETER J	ALLEGHENY
JANOFF, HAL B	STUDENT
JANORA, MD, DEANNA M	PHILADELPHIA
JANOSKO, MD, RUDOLPH E M	ALLEGHENY
JANSEN, MD, BRUCE M	ALLEGHENY
JANSMA JR, MD, DAVID R	BEAVER
JANSON, MD, RUSSELL R	DAUPHIN
JANTON III, MD, FRANCIS J	DAUPHIN
JANZER, MD, SEAN F	PHILADELPHIA
JAQUISS, MD, G WILLIAM	ALLEGHENY
JARAMILLO, MD, BEVERLY ANN	ALLEGHENY
JARDINE, JILL C	STUDENT
JARDINE, LISA M	STUDENT
JARIWALA, MD, LETICIA Q	ALLEGHENY
JARMAN, MD, MARTHA L	BUCKS
JARMOLOWSKI, MD, CHESTER R	ALLEGHENY
JAROSH, MD, SAMARA L	PHILADELPHIA
JAROWENKO, MD, DALEELA G	LANCASTER
JARRAH, LORRAINE F	STUDENT
JARRETT, MD, FREDRIC	ALLEGHENY
JARRETT, MD, PATRICIA J	ALLEGHENY
JARVIS, MD, F WAYNE	PHILADELPHIA
JARYMOVYCH, MD, JAROSLAW I	PHILADELPHIA
JASPER, DO, RONALD L	ALLEGHENY
JAURIGUE, MD, VENERANDO G	PHILADELPHIA
JAVAN, MD, MEHDI B	WESTMORELAND
JAWAD, MD, BASIL S	CHESTER
JAXHEIMER, MD, ERIC C	BERKS
JAY JR, MD, W THOMAS	BERKS
JAYAKUMAR, MD, SUBRAMONIAM	WASHINGTON
JEFFERIES III, MD, GEORGE E	DAUPHIN
JEFFERS, MD, JOHN B	PHILADELPHIA
JEFFREYS, MD, WILLIAM H	MONTOUR
JEFFRIES, MD, C STEPHEN	ALLEGHENY
JEFFRIES, DO, NANCY E	LANCASTER
JEGASOTHY, MD, BRIAN V	ALLEGHENY
JELEN, MD, JOSEPH A	PHILADELPHIA
JELEN, MD, JOSEPH A	PHILADELPHIA
JENCKES III, MD, GEORGE A	BERKS
JENKINS, MD, BARRY L	SCHUYLKILL
JENKINS, MD, BENJAMIN C	BLAIR

JENKINS, MD, DONELLA	DELAWARE
JENKINS, MD, DOROTHY S	DELAWARE
JENKINS, MD, JAY L	ERIE
JENKINS, MD, ROSEMARY	DAUPHIN
JENKINS III, ARTHUR L	STUDENT
JENKINS JR, MD, JULE	PHILADELPHIA
JENKINS JR, MD, ROBERT J	ALLEGHENY
JENKS, MD, JOHN S	PHILADELPHIA
JENNEY, MD, FLORENCE S	BUTLER
JENNINGS, MD, DAVID T	LYCOMING
JENNINGS, JAMES E	STUDENT
JENNINGS, MD, RICHARD A	ALLEGHENY
JENOFSKY, MD, JACK	PHILADELPHIA
JENS, MD, KURTIS D	LANCASTER
JENSEN, MD, GORDON L	MONTOUR
JENSEN, MD, NANCY L	PHILADELPHIA
JESICK, MD, ANN R	INDIANA
JESSAR, MD, RALPH A	PHILADELPHIA
JETTER, MD, WALTER W	WESTMORELAND
JEW III, MD, EDWARD W	ALLEGHENY
JEW JR, MD, EDWARD W	ALLEGHENY
JEWART, MD, BRIAN H	ALLEGHENY
JEWELL, MD, MELANIE	PHILADELPHIA
JEWELLS, DO, VALERIE L	CHESTER
JEYARANJAN, MD, A RICHARD	NORTHAMPTON
JHO, MD, HAE DONG	ALLEGHENY
JIMENEZ-MEDINA, MD, EVELYN E	MONTGOMERY
JIMENEZ-MEDINA, MD, HERNAN J	MONTGOMERY
JIMERSON, MD, CEDRIC C	BERKS
JIN, MD, BYUNGHAK	FAYETTE
JOCHNOWITZ, MD, MICHAEL J	MONTGOMERY
JOCO, MD, DAVID G	LYCOMING
JOE, BONNIE N	STUDENT
JOFFE, DO, RALF	YORK
JOHAN, MD, MORTON	ALLEGHENY
JOHANSON, MD, NORMAN A	PHILADELPHIA
JOHN, MD, BENJAMIN	LUZERNE
JOHN, MD, JOHN P	ALLEGHENY
JOHN, MD, LAWRENCE R	ALLEGHENY
JOHN, MD, MALIYAKKAL J	COLUMBIA
JOHN, MD, REKHA A	PHILADELPHIA
JOHN, MD, THOMAS	DELAWARE
JOHN, EXEC DIR, PAUL P	LYCOMING
JOHNS, MD, CHRISTOPHER M	ALLEGHENY
JOHNS, DO, DAVID C	CAMBRIA
JOHNS, MD, MILTON W	LANCASTER
JOHNS IV, MD, WALTER S	ERIE
JOHNSON, MD, ALFRED T	BERKS
JOHNSON, MD, BERNETT L	PHILADELPHIA
JOHNSON, MD, BRETT A	ERIE
JOHNSON, MD, CARL G	LANCASTER
JOHNSON, MD, CHARLES F	LEHIGH
JOHNSON, MD, CRAIG H	BERKS
JOHNSON, MD, DANIEL W	BLAIR
JOHNSON, MD, DAVID W	ALLEGHENY
JOHNSON, MD, DENNIS R	YORK
JOHNSON, DEREK K	STUDENT
JOHNSON, MD, DON E	PHILADELPHIA
JOHNSON, MD, DOROTHY E	LUZERNE
JOHNSON, MD, DOUGLAS E	LEHIGH
JOHNSON, DO, DWIGHT C	PHILADELPHIA
JOHNSON, EDWARD P	STUDENT
JOHNSON, MD, ELTING C	BRADFORD
JOHNSON, MD, FRANKLIN P	ALLEGHENY
JOHNSON, MD, GARY E	ALLEGHENY
JOHNSON, MD, GEORGE M	YORK
JOHNSON, MD, GLEN	BRADFORD
JOHNSON, MD, JAMES R	ALLEGHENY
JOHNSON, MD, JOAN E	LANCASTER
JOHNSON, MD, JOHN H	BLAIR
JOHNSON, MD, JONAS T	ALLEGHENY
JOHNSON, MD, LISA B	CHESTER
JOHNSON, MD, LYNN R	ALLEGHENY
JOHNSON, MD, MARGARET M	PHILADELPHIA
JOHNSON, MD, PETER C	ALLEGHENY
JOHNSON, MD, RAYMOND A	MONTGOMERY
JOHNSON, MD, RICHARD B	CRAWFORD
JOHNSON, DO, RICHARD E	JEFFERSON
JOHNSON, MD, ROBERT P	LANCASTER
JOHNSON, MD, ROBERTA M	CLINTON
JOHNSON, MD, THOMAS A	PHILADELPHIA
JOHNSON, MD, VAN W	WARREN
JOHNSON, MD, WAINE C	PHILADELPHIA
JOHNSON, MD, WILLIAM T	BERKS
JOHNSON III, MD, S HARRIS	ALLEGHENY
JOHNSON JR, DO, ALLAN C	ERIE
JOHNSON JR, MD, BERTRAM L	LANCASTER
JOHNSON JR, MD, HOWARD J	PHILADELPHIA
JOHNSON-HAMERMAN, MD, LOIS M	PHILADELPHIA
JOHNSONBAUGH, MD, ROGER E	DELAWARE
JOHNSTON, DO, CRAIG T	ERIE
JOHNSTON, MD, EUGENE V	LANCASTER
JOHNSTON, MD, FRANK B	PHILADELPHIA
JOHNSTON, MD, JAMES B	VENANGO
JOHNSTON, MD, JAMES R	ALLEGHENY
JOHNSTON III, MD, JAMES R	CUMBERLAND
JOHNSTON JR, MD, JOHN A	ALLEGHENY
JOHNSTONE, MD, GRAHAM F	ALLEGHENY
JOLLY, MD, RAJ K	ELK/CAMERON
JONES, MD, ANCIL A	DELAWARE
JONES, MD, ANDREW R	DELAWARE
JONES, MD, BRIAN C	ALLEGHENY
JONES, MD, DANIEL C	MONTGOMERY
JONES, MD, DAVID G	LEHIGH
JONES, MD, DAVID J	YORK
JONES, MD, EDWARD L	BRADFORD
JONES, MD, EDWARD R	PHILADELPHIA
JONES, MD, FRANK E	ALLEGHENY
JONES, MD, FREDERICK L	HUNTINGDON
JONES, MD, GEORGE J	WASHINGTON
JONES, JAMES B	STUDENT
JONES, MD, JAMES E	DAUPHIN
JONES, DO, JEFFREY J	BERKS
JONES, MD, JOSEPH C	ADAMS
JONES, MD, LARRY M	WASHINGTON
JONES, MD, LARRY W	BLAIR
JONES, MD, MICHAEL W	LYCOMING
JONES, MD, NEIL F	ALLEGHENY
JONES, MD, PATRICIA H	PHILADELPHIA
JONES, MD, RAYMOND R	CHESTER
JONES, RENEE L	STUDENT
JONES, MD, RICHARD E	ADAMS
JONES, MD, ROBERT K	DELAWARE
JONES, MD, ROBYN R	PHILADELPHIA
JONES, MD, STEVEN R	ALLEGHENY
JONES, MD, STUART A	LEHIGH
JONES, THEODORE D	STUDENT
JONES, MD, TOM B	MERCER
JONES, DO, WAYNE T	YORK
JONES, MD, WENDELL E	ALLEGHENY
JONES JR, MD, FREDERICK L	MONTOUR
JONES JR, MD, JOHN H	LYCOMING
JONES JR, DO, ROBERT S	LACKAWANNA
JONES JR, MD, ROBERT T	ALLEGHENY
JONES JR, MD, ROBERT W	ALLEGHENY
JONES-GORDON, MD, SANDRA M	ALLEGHENY
JORDAN, MD, CLAUS G	MONROE
JORDAN, MD, JEROME W	LACKAWANNA
JORDAN, MD, WILLIAM P	MONROE
JORDAN, MD, WM J	LACKAWANNA
JORDAN III, MD, WALTER E	LACKAWANNA
JORGE, MD, EDUARGO	DAUPHIN
JORGENSEN, MD, BRIAN K	PHILADELPHIA
JORGENSON, JOEL J	STUDENT
JORKASKY, MD, DIANE K	PHILADELPHIA
JOSEF, MD, STANLEY S	PHILADELPHIA
JOSEPH, MD, ALFRED J	MERCER
JOSEPH, MD, ANDREW H	ALLEGHENY
JOSEPH, MD, ELAINE R	ALLEGHENY
JOSEPH, MD, GEOFFREY	WESTMORELAND
JOSEPH, MD, GEORGE M	NORTHAMPTON
JOSEPH, MD, KADANKAVIL C	ELK/CAMERON
JOSEPH, MD, RAYMOND J	LUZERNE
JOSHI, MD, HARENDRA V	PHILADELPHIA
JOSHI, MD, KISHOR E	FAYETTE
JOSHI, MD, KUNDABALA S	PHILADELPHIA
JOSHI, MD, MANOHAR J	ALLEGHENY
JOSIAH, MD, RANJIT C	PHILADELPHIA
JOSON, MD, RAYMOND M	PHILADELPHIA
JOSSELSON, MD, ALAN S	MONTGOMERY
JOURDAIN, MD, LUIS M	BLAIR
JOVANOVICH, MD, DANIEL B	ALLEGHENY
JOY, MD, CHARLES A	ERIE
JOY, MD, CHARLES R	ERIE
JOYCE, MD, JUDITH M	ALLEGHENY
JOYCE, MD, KEVIN F	WASHINGTON
JOYCE, MD, MICHAEL F	MONTGOMERY
JOYNER, MD, DAVID M	DAUPHIN
JOZEFCZYK, MD, PATRICIA B	ALLEGHENY
JU, BRIAN S	STUDENT
JUANG, MD, RICHARD C	ERIE
JUBELIRER, MD, ROBERT A	MONTGOMERY
JUDD, MD, JAMES D	MONTGOMERY
JUDE, MD, DAVID C	ALLEGHENY
JUDGE, MD, JOHN D M	NORTHUMBRLAND
JUDGE, MD, SHEILA	PHILADELPHIA
JUDGE III, MD, JAMES W	CHESTER
JUDSON, MD, JOHN P	DAUPHIN
JUDSON, MD, WILLIAM W	LYCOMING
JUHASZ, MD, ALEX B	INDIANA
JULES, MD, ARNOLD J	MONTGOMERY
JULIA, MD, RONALD R	NORTHAMPTON
JULIAN, MD, MARYJANE A	SCHUYLKILL
JULIAN, MD, THOMAS B	ALLEGHENY
JULIEN, TYA-MAE Y	STUDENT
JULIUS, MD, ERNEST L	LUZERNE
JUNCO JR, MD, ANTHONY	WASHINGTON
JUNCOS, MD, GUILLERMO R	CHESTER
JUNEJA, MD, DAMYANTI	PHILADELPHIA
JUNG, MD, HONG I	LACKAWANNA
JUNG, MD, JAY SOO	LEHIGH
JUNG, MD, JENNIFER L	BUCKS
JUNG, MD, TINJUNG	MCKEAN
JUNGREIS, MD, CHARLES A	ALLEGHENY
JUNKIN, MD, DAVID M	MONTGOMERY
JUNOD, MD, JOHN B	BUCKS
JURBALA, BRIAN M	STUDENT
JURENOVICH, DO, MICHAEL J	MERCER
JURGENS, MD, KENNETH H	ERIE
JURGENSEN, MD, JOHN C	CUMBERLAND
JURNOVOY, MD, JOEL B	DELAWARE
JUSTICE, WILLIAM H	STUDENT
JUSTIN, MD, PETER A	NORTHUMBERLAND
JUSTMAN, MD, JUDITH I	PHILADELPHIA
JUTTNER, MD, HANS U	FRANKLIN
JUVELIER, MD, BERNARD W	DAUPHIN

K

KAAR, MD, RICHARD C	LYCOMING
KABLER, MD, RONALD L	MONTOUR
KACHEL, MD, THOMAS A	DAUPHIN
KACZMARCZYK, MD, THEODORE R	LACKAWANNA
KACZOR, MD, STANLEY F	BLAIR
KADIS, MD, MILTON H	LUZERNE
KADRY, MD, ZAKIYAH	ALLEGHENY
KAFRISSEN, MD, STEVEN R	LUZERNE
KAGUYUTAN, MD, ALFREDO G	ADAMS
KAGUYUTAN, MD, OFELIA D	ADAMS
KAHLER, MD, GERALD W	VENANGO
KAHLER, MD, ROBERTA A	VENANGO
KAHN, MD, BERNARD L	PHILADELPHIA
KAHN, MD, BERTRAM	MONTGOMERY
KAHN, MD, DONALD L	PHILADELPHIA
KAHN, MD, HYMAN R	PHILADELPHIA
KAHN, MD, MARK S	PHILADELPHIA
KAHN, MD, RONALD L	BRADFORD
KAHN, MD, S BENHAM	PHILADELPHIA
KAHN, MD, SANDRA J	PHILADELPHIA
KAHN, MD, Y RAYMOND	ARMSTRONG
KAHWASH, MD, SAMIR B	ALLEGHENY
KAIDBEY, MD, KAYS	PHILADELPHIA
KAIN III, MD, THOMAS M	DELAWARE
KAIRYS, MD, LEO R	ALLEGHENY
KAIRYS, MD, MARIE Z	PHILADELPHIA
KAISER, MD, PAUL K	PHILADELPHIA
KAISER, MD, RALPH H	LYCOMING
KAISSI, MD, CATHY A	BUCKS
KAJANI, MD, MEHDI K	PHILADELPHIA
KAJI, MD, ARJUN V	STUDENT
KAJI, MD, VIKRAM H	BUCKS
KAKODKAR, MD, VASUNDHARA S	NORTHAMPTON
KALAGAYAN, MD, HECTOR J	ERIE
KALANI, MD, GHASSEM	PHILADELPHIA
KALASH, MD, YASER	ALLEGHENY
KALCHMAN, MD, STEVEN H	BUCKS
KALENAK, MD, ALEXANDER	DAUPHIN
KALES, MD, ANTHONY	DAUPHIN
KALIA, MD, KAMAL K	ALLEGHENY
KALIK, DO, JOSEPH R	MERCER
KALIMAN, MD, EDWARD G	ALLEGHENY
KALISH, ERIC D	STUDENT
KALISH, MD, ROBERT W	PHILADELPHIA
KALKHOF, MD, THOMAS C	ERIE
KALLA, MD, RICHARD L	ALLEGHENY
KALLOZ, MD, JOHN R	ADAMS
KALMANSON, MD, JACOB D	ALLEGHENY
KALNICKI, MD, SHALOM	ALLEGHENY
KALODNER, DO, DAVID R	DELAWARE
KALRA, MD, KRISHAN G	ALLEGHENY
KAM, MD, LAURANCE W	ALLEGHENY
KAMAKA, MD, MARTINA L	LANCASTER
KAMAT, VINAY	STUDENT
KAMBIN, MD, PARVIZ	PHILADELPHIA
KAMDAR, MD, JAYANT C	PHILADELPHIA
KAMEEN, MD, ANTHONY J	LUZERNE
KAMELGARD, MD, JOSEPH I	PHILADELPHIA
KAMELGARD, MD, NAOMI S	PHILADELPHIA
KAMEN, DO, LEONARD S	PHILADELPHIA
KAMERER, MD, DONALD B	ALLEGHENY
KAMERLING, MD, JOSEPH M	PHILADELPHIA
KAMINENI, MD, UMA	PHILADELPHIA
KAMINSKI, MD, ROBERT J	ALLEGHENY
KAMINSKI, MD, THOMAS N	WESTMORELAND
KAMINSKY, MD, JAMES F	ERIE
KAMNANI, MD, ASHA J	PHILADELPHIA
KAMSLER, MD, DAVID F	ADAMS
KANDABAROW, MD, ALEXANDER	ALLEGHENY
KANDRA, MD, JOSEPH J	DAUPHIN
KANDULA, MD, RAVINDRA R	NORTHAMPTON
KANE, MD, JAMES A	LACKAWANNA
KANE, MD, JOAN D	LANCASTER
KANE, MD, JOHN J	ALLEGHENY
KANE, MD, JOHN S	MONTGOMERY
KANE, MD, KEVIN M	ALLEGHENY
KANE, MARK J	STUDENT
KANE, DO, PATRICIA B	BERKS
KANE, MD, PATRICK L	ALLEGHENY
KANE, MD, RUTH P	ALLEGHENY
KANE, MD, WILLIAM M	DELAWARE
KANE III, MD, JOHN M	ALLEGHENY
KANEFF, MD, SCOTT R	PHILADELPHIA
KANEFIELD, DO, MARVIN	PHILADELPHIA
KANEHANN, MD, LISA B	PHILADELPHIA
KANENSON, MD, WILLIAM L	DAUPHIN
KANG, PAUL B	STUDENT
KANG, MD, SE-BOO	ARMSTRONG
KANIA, MD, ROBERT J	ALLEGHENY
KANIECKI, MD, ROBERT G	ALLEGHENY
KANIECKI, MD, VIDA S	ALLEGHENY
KANIS, MD, MYRON L	PHILADELPHIA
KANN, MD, DAVID	CUMBERLAND
KANN, MD, JULES	ALLEGHENY
KANN, MD, STEVEN E	ALLEGHENY
KANNAN, MD, VAIDEHI	DELAWARE
KANOFF, DO, RICHARD B	PHILADELPHIA
KANOFF, MD, STEVEN J	NORTHAMPTON
KANOUSE, MD, GARY D	COLUMBIA
KANSAGRA, MD, ASHWIN M	PHILADELPHIA
KANSAGRA, MD, JASMAT N	CAMBRIA
KANSAL, MD, KUSUM R	BLAIR
KANSAL, MD, RAJ G	BLAIR
KANT, MD, NAVAL	UNION
KANT, MD, NILA N	UNION
KANTER, MD, FRANK J	PHILADELPHIA
KANTER, MD, STEVEN L	ALLEGHENY
KANTOR, EDWARD M	STUDENT
KANTOR, DO, JAMES G	PHILADELPHIA
KANTOR, MD, ROBERT J	DAUPHIN
KANTOR, MD, THOMAS V	LEBANON
KANWIT, MD, BERT A	LEHIGH
KAO, MD, CHIEN-KUO	ALLEGHENY
KAO, MD, LIDIA WEI LIU	ALLEGHENY
KAO, MD, YI H	CLEARFIELD
KAO, MD, YU SONG	LUZERNE
KAPADIA, MD, DILIP L	DELAWARE
KAPCALA, DO, JAN S	MONROE
KAPCAR, MD, ANDREW J	LUZERNE
KAPLAN, MD, CARL	ALLEGHENY
KAPLAN, DAVID B	STUDENT
KAPLAN, MD, FRANK E	MONTGOMERY
KAPLAN, MD, LAWRENCE M	BERKS
KAPLAN, MD, PETER D	ALLEGHENY
KAPLAN, MD, RANDY	CRAWFORD
KAPLAN, MD, RICH M	STUDENT
KAPLAN, MD, RICHARD H	PHILADELPHIA
KAPLAN, MD, ROBERT D	PHILADELPHIA
KAPLAN, MD, ROBIN L	BERKS
KAPLAN, MD, SHELDON J	BERKS
KAPLAN, MD, STEPHEN M	BLAIR
KAPLAN, MD, SUSAN G	DELAWARE
KAPLOW, MD, GWEN H	PHILADELPHIA
KAPOOR, MD, ARUN A	ALLEGHENY
KAPOOR, MD, RAJESHWAR D	ALLEGHENY
KAPOOR, MD, WISHWA N	ALLEGHENY
KAPPAKAS, MD, GEORGE S	ALLEGHENY
KARA, MD, AOUN B	NORTHAMPTON
KARABELNIK, MD, DON	BERKS
KARAFIN, MD, LEBTER	PHILADELPHIA
KARALIS, MD, DEAN G	PHILADELPHIA
KARAMANIAN, MD, AGOP V	ERIE
KARAMCHANDANI, MD, NILIMA T	ALLEGHENY
KARAMCHETI, MD, ANAND	WASHINGTON
KARANDY, DO, EMELY	PHILADELPHIA
KARANJIA, MD, MINOO D	INDIANA
KARASICK, MD, SHELDON R	PHILADELPHIA
KARAYANNIS, MD, BABIL N	DELAWARE
KARCSH, DO, HENRY J	CHESTER
KARDISH, MD, THOMAS J	BUCKS
KARDON, DO, RICHARD E	PHILADELPHIA
KARDUCK, MD, JOHN S	CAMBRIA
KAREHA, MD, LOUIS G	LACKAWANNA
KARESS, MD, GINA M	LEHIGH
KARETAS, MD, ALEXANDRA I	PHILADELPHIA
KARFEL, DO, BARRY M	PHILADELPHIA
KARIAN, MD, JOHN M	VENANGO
KARIMKHANI, MD, KOBRA	ALLEGHENY
KARKANIAS, MD, CHEROLYN	MONTGOMERY
KARLE, MD, JOHN G	ERIE
KARLIN, DO, PAUL S	PHILADELPHIA
KARLSTADT, MD, ROBYN GAIL	PHILADELPHIA
KARNIK, MD, SUBASH S	BUCKS
KARP, MD, JOSEPH S	PHILADELPHIA
KARP, MD, LOUIS A	PHILADELPHIA
KARPF, MD, MICHAEL	ALLEGHENY
KARPIN, MD, MAX	DELAWARE
KARPINSKI JR, MD, FELIX E	MONTGOMERY
KARPINSKI JR, MD, STEPHEN J	ALLEGHENY
KARRON, MD, BETTY	LEHIGH
KARSCHNER, MD, JANET K	ALLEGHENY
KARSH, MD, CARL A	ERIE
KART, MD, BARRY H	ALLEGHENY
KARUMBAYA, MD, ROMOLA	LACKAWANNA
KARUNARATNE, MD, ESIRI R	BLAIR
KARVER, MD, SLOAN B	MONROE
KASALES, MD, CLARENCE J	LEBANON
KASALES, MD, CLAUDIA J	DELAWARE
KASARDA, MD, FRANCES E	PHILADELPHIA
KASDAN, MD, RICHARD B	ALLEGHENY
KASDIN, MD, SHARON L	PHILADELPHIA
KASE, GAIL Y	STUDENT
KASE, MD, JAMES J	BERKS
KASE, MD, PAUL F	DAUPHIN
KASE, MD, WM A	PHILADELPHIA
KASEFF, MD, LEON G	PHILADELPHIA
KASEY, MD, GLORIA R	ALLEGHENY
KASHATUS, MD, WM C	PHILADELPHIA
KASHURBA, MD, GLENN J	SOMERSET
KASHURBA, MD, MARY T	SOMERSET
KASIRSKY, DO, GILBERT	BUCKS
KASPAR, MD, ALBERT J	NORTHAMPTON
KASPAR, MD, JOHN V	DAUPHIN
KASPARIAN, MD, HRATCH	PHILADELPHIA
KASPER, MD, KEVIN J	DELAWARE
KASPRENSKI, MD, MATTHEW A	LEHIGH
KASPRENSKI, MD, MATTHEW L	LEHIGH
KASPUTIS, MD, DAVID A	COLUMBIA
KASS, MD, LAWRENCE E	YORK
KASS, DO, RICHARD W	PHILADELPHIA
KASTELIC, MD, RICHARD M	CAMBRIA
KASTENBAUM, MD, MICHAEL	BERKS
KASTENBERG, MD, DAVID M	PHILADELPHIA
KASTRUP, MD, JOHN J	ERIE
KASUMI, MD, ASAO	LEHIGH
KASUNDRA, MD, PARSHOTTAM N	SCHUYLKILL
KATALAN, MD, MAURICE M	PHILADELPHIA
KATCHMAN, MD, STACY D	PHILADELPHIA
KATES, MD, JONATHAN L	SOMERSET
KATES, LISA C	STUDENT
KATES, MD, MALCOLM	PHILADELPHIA
KATIN, MD, LAWRENCE I	DELAWARE
KATLIC, MD, MARK R	LUZERNE
KATOWITZ, MD, JAMES A	PHILADELPHIA
KATSAMPES, MD, ERNEST T	DAUPHIN
KATSETOS, MD, CHRISTOS D	PHILADELPHIA
KATTELMAN, DO, MARC	MONTGOMERY
KATZ, MD, DAVID L	ALLEGHENY
KATZ, MD, DAVID M	PHILADELPHIA
KATZ, MD, DOUGLAS A	DAUPHIN
KATZ, MD, IRWIN L	ALLEGHENY
KATZ, MD, JACOB	PHILADELPHIA
KATZ, MD, JANICE D	PHILADELPHIA
KATZ, MD, JERALD M	WESTMORELAND
KATZ, MD, JOSEPH	LANCASTER
KATZ, MD, JULES	PHILADELPHIA
KATZ, MD, JULIAN	PHILADELPHIA
KATZ, MD, KATHLEEN M	MONTGOMERY
KATZ, MD, LAURENCE M	ALLEGHENY
KATZ, MD, LEO	PHILADELPHIA

KATZ, MD, LESLIE J PHILADELPHIA
KATZ, MD, M RICHARD PHILADELPHIA
KATZ, MD, MAX PHILADELPHIA
KATZ, MD, RICHARD G ALLEGHENY
KATZ, MD, RICHARD H PHILADELPHIA
KATZ, MD, RICHARD I PHILADELPHIA
KATZ, MD, ROBERT E MONTGOMERY
KATZ, MD, SHEILA M PHILADELPHIA
KATZ, DO, STEVEN LEE PHILADELPHIA
KATZ, MD, STUART I MONTGOMERY
KATZ, MD, WARREN A PHILADELPHIA
KATZ, MD, WILLIAM ALLEGHENY
KATZIN, MD, DICK ALLEGHENY
KATZMAN, MD, JEFFREY I CHESTER
KAUDERER JR, MD, JOHN G MONROE
KAUFF, NOAH D STUDENT
KAUFFMAN, MD, CHESTER T INDIANA
KAUFFMAN, MD, DWIGHT A LANCASTER
KAUFFMAN, MD, GORDON L DAUPHIN
KAUFFMAN, MD, M LUTHER MONTGOMERY
KAUFFMAN, PATRICIA J STUDENT
KAUFFMAN, MD, WILLIAM S CUMBERLAND
KAUFFMAN JR, DO, JOHN M LEHIGH
KAUFMAN, MD, ALAN C BUCKS
KAUFMAN, MD, BARRE D LEHIGH
KAUFMAN, MD, CLARK R LANCASTER
KAUFMAN, MD, JAY H LEHIGH
KAUFMAN, MD, JODI D PHILADELPHIA
KAUFMAN, MD, STEPHEN E MONTGOMERY
KAUFMANN, MD, MICHAEL W LEHIGH
KAUH, EUNKYUNG A STUDENT
KAUR, MD, MANJEET LANCASTER
KAUR, MD, PRAKASH WESTMORELAND
KAUSHIK, MD, VED P ALLEGHENY
KAVCHOK, MD, JOSEPH LEHIGH
KAVEE, MD, ELLEN H PHILADELPHIA
KAVIC, MD, MICHAEL S ALLEGHENY
KAVIC, MD, THOMAS A ALLEGHENY
KAVIC, MD, TIMOTHY N ALLEGHENY
KAVILLE, MD, ROBERT W LACKAWANNA
KAVJIAN, MD, EDWARD M DELAWARE
KAY, MD, GORDON PHILADELPHIA
KAY, MD, HAROLD R PHILADELPHIA
KAY, MD, MICHAEL L PHILADELPHIA
KAYE, MD, ANDREW S ALLEGHENY
KAYE, MD, DONALD PHILADELPHIA
KAYE, MD, KENDRA B PHILADELPHIA
KAZEM, MD, ISMAIL PHILADELPHIA
KEAGLE, DO, DOUGLAS L DELAWARE
KEAGY, DO, GREGORY S DAUPHIN
KEAN, MD, DENNIS W LEHIGH
KEAN, MD, HERBERT PHILADELPHIA
KEANE, KIMBERLY A STUDENT
KEANE, MD, WILLIAM M PHILADELPHIA
KEARNEY, MD, JAMES D DAUPHIN
KEARNEY, MD, JOHN M BERKS
KEARNEY, MD, JOSEPH A WESTMORELAND
KEARNEY, DO, STARR M ELK/CAMERON
KEARNS, MD, THOMAS R WASHINGTON
KEATES, MD, EDWIN U PHILADELPHIA
KEATING, MD, EDWARD C LYCOMING
KEATING, MD, PAUL J DELAWARE
KEBLISH, DAVID J STUDENT
KEBLISH JR, MD, PETER A LEHIGH
KECK, MD, WILLIAM S WESTMORELAND
KEDARNATH, MD, SIVA ALLEGHENY
KEDDIE, MD, ROLAND T ALLEGHENY
KEECH JR, MD, HAYDEN G YORK
KEEDY, MD, JENNIFER L MONTGOMERY
KEEFER, MD, GEORGE P PHILADELPHIA
KEELER, DO, VIRGINIA E M LUZERNE
KEEN, MD, FREDERICK K ALLEGHENY
KEEN JR, MD, WILLIAM D PHILADELPHIA
KEENAN, MD, MARY ANN E PHILADELPHIA
KEENAN JR, MD, WILLIAM F LYCOMING
KEENEY, MD, GALEN E DAUPHIN
KEEPORTS, MD, RICHARD L YORK
KEFFER, MD, WILLIAM H BERKS
KEGEL, MD, DANIEL P LANCASTER
KEGEL, MD, EUGENE E LANCASTER
KEGEL, MD, JEFFREY G PHILADELPHIA
KEGEL, MD, MARY F LANCASTER
KEHM, MD, ROBERT F YORK
KEHM, MD, VINCENT A YORK
KEHRLI, MD, HENRY J LACKAWANNA
KEHRLI, MD, WILLIAM H LACKAWANNA
KEIL, MD, LORETTA W LEHIGH
KEIL, MD, STEPHEN M CENTRE
KEIM, MD, PETER J ARMSTRONG
KEISER, MD, E LEE BERKS
KEISMAN, MD, ROBERT A DELAWARE
KEIT, MD, JOAN PHILADELPHIA
KEITER, MD, JAMES M LEBANON
KEITH, MD, HELEN R H NORTHAMPTON
KELBICK, MD, ELAINE H PHILADELPHIA
KELLER, MD, DAVID A STUDENT
KELLER, MD, FRANK M ALLEGHENY
KELLER, GREG S STUDENT
KELLER, MD, JAMES W LEBANON
KELLER, DO, JON M LANCASTER
KELLER, MD, LYNWOOD V BERKS
KELLER, MD, RAY E MONTOUR
KELLERMAN, MD, ANDREW D ALLEGHENY
KELLERMAN, MD, WILMA C MONTGOMERY
KELLEY, MD, JAMES M ALLEGHENY
KELLEY, MD, KRISTINE LACKAWANNA
KELLEY, DO, SUZANNE K DAUPHIN
KELLEY, MD, WILLIAM N PHILADELPHIA
KELLEY JR, MD, CHARLES F LEHIGH
KELLIS, MD, DANA S CAMBRIA
KELLMAN, MD, IAN A WYOMING
KELLY, MD, ANNE M PHILADELPHIA
KELLY, MD, BRUCE R ALLEGHENY
KELLY, MD, EDWARD A DELAWARE
KELLY, MD, EDWARD G ALLEGHENY
KELLY, MD, EDWARD J LACKAWANNA
KELLY, MD, HABIB R PHILADELPHIA
KELLY, MD, HERBERT T PHILADELPHIA
KELLY, MD, JAMES E MONTOUR
KELLY, MD, JAMES J DELAWARE
KELLY, MD, JEAN A NORTHAMPTON
KELLY, MD, JOHN A BRADFORD
KELLY, MD, JOHN J MONTGOMERY
KELLY, MD, KAREN A CUMBERLAND
KELLY, MD, KEN F PHILADELPHIA
KELLY, MD, KEVIN J DAUPHIN
KELLY, MD, MARK F DELAWARE
KELLY, MD, ROBERT W ARMSTRONG
KELLY, MD, THOMAS J ALLEGHENY
KELLY, MD, WILLIAM E PHILADELPHIA
KELLY, MD, WILLIAM J ALLEGHENY
KELLY IV, MD, JOHN D PHILADELPHIA
KELLY JR, MD, EDWARD A CHESTER
KELSEY, MD, ALICE M HUNTINGDON
KELSEY, MD, DAVID M DELAWARE
KELSO, MD, DON R MONTGOMERY
KELTON, MD, FRANKLIN C MONTGOMERY
KELVIN, MD, CARL B PHILADELPHIA
KEMP, MD, ROBERT M LANCASTER
KEMP, MD, WILLIAM R ALLEGHENY
KEMP III, MD, DEWITT E CAMBRIA
KEMPF JR, MD, FRANCIS C PHILADELPHIA
KEMPNER, BONNIE A STUDENT
KEMRER, MD, J DONALD LANCASTER
KENDALL, MD, A RICHARD PHILADELPHIA
KENDALL, MD, BENJAMIN PHILADELPHIA
KENDALL, MD, LEIGH W LANCASTER
KENEALY, MD, SHAHIRA H DELAWARE
KENIG, MD, ISADOR J DAUPHIN
KENKEL, MD, DELIA R BLAIR
KENKRE, MD, SRICRISHNA B ALLEGHENY
KENNA, MD, JOSEPH P LANCASTER
KENNA, MD, MARGARET A ALLEGHENY
KENNA, MD, MARITA D ALLEGHENY
KENNARD, MD, JOHN F CLEARFIELD
KENNEDY, DAVID S STUDENT
KENNEDY, MD, F BRYAN ALLEGHENY
KENNEDY, MD, JOHN N LUZERNE
KENNEDY, MD, JOHN W STUDENT
KENNEDY, DO, JULIA M BUCKS
KENNEDY, MD, NELSON M BEAVER
KENNEDY, MD, PATRICK J DELAWARE
KENNEDY, MD, PETER S YORK
KENNEDY, MD, RICHARD P MONROE
KENNEDY, MD, SHIRLEY A WESTMORELAND
KENNEDY, MD, THOMAS I BUCKS
KENNEDY, MD, THOMAS L MONTOUR
KENNEDY III, MD, ARTHUR R CARBON
KENNEN JR, DO, EUGENE W WESTMORELAND
KENNERDELL, MD, EDWARD H ALLEGHENY
KENNERDELL, MD, JOHN S ALLEGHENY
KENNEY, MD, DAVID A WESTMORELAND
KENNEY, MD, LAWRENCE E MONTGOMERY
KENNING, MD, JAMES A MONTGOMERY
KENNY, MD, KEVIN J ALLEGHENY
KENNY, MD, MICHAEL R COLUMBIA
KENT, MD, GEORGE M LANCASTER
KENT, MD, RICHARD B CHESTER
KENT, MD, W DAVID FRANKLIN
KENVIN, MD, JOHN E LEHIGH
KENWORTHY JR, MD, HARRY J MONTGOMERY
KENYON, MD, LAWRENCE C PHILADELPHIA
KENZAKOWSKI, LEO F STUDENT
KEOHANE, MD, DENIS J STUDENT
KEON, MD, THOMAS P PHILADELPHIA
KEPERLING, DO, MARY O YORK
KEPLER, MD, FURMAN T DELAWARE
KEPP, MD, EDWARD A VENANGO
KERESZTURY, MD, MICHAEL F PHILADELPHIA
KERMAN, MD, KEITH M PHILADELPHIA
KERN, MD, FRANK MONTGOMERY
KERN, MD, FRANKLIN M PHILADELPHIA
KERNICH, MD, JOSEPH J JEFFERSON
KERR, MD, COLIN P LEBANON
KERR, MD, JOHN H PHILADELPHIA
KERR, MD, KRISS M YORK
KERR, MD, PAUL B SUSQUEHANNA
KERR, MD, ROBERT M LUZERNE
KERR JR, MD, CLARK M WESTMORELAND
KERR JR, MD, HARRY J ALLEGHENY
KERRIGAN, MD, JAMES J MONROE
KERRIGAN, DO, PATRICK J LUZERNE
KERRY, MD, ROY E MERCER
KERSHBAUM, MD, CAROL M MONTGOMERY
KERSHNER, MD, MARILYN S BERKS
KERSON, MD, LAWRENCE A MONTGOMERY
KERSTEEN, EXEC DIR, DUANE E LUZERNE
KERSTEIN, MD, MORRIS D PHILADELPHIA
KERSTETTER, MD, DAVID L BEDFORD
KERSTING, MD, JOHN W BRADFORD
KESACK, ANDREA F STUDENT
KESSEL, MD, LAWRENCE J PHILADELPHIA
KESSELRING JR, MD, WILLIAM T MONROE
KESSERU, MD, JULIUS ALLEGHENY
KESSLER, MD, FRANK J NORTHAMPTON
KESSLER, MD, GALEN M ALLEGHENY
KESSLER, MD, LAIBE A ALLEGHENY
KESSLER, MD, REX K DELAWARE
KESSLER, MD, WOODROW B DELAWARE
KESTER, MD, WALTER L CHESTER
KESWANI, MD, ASHOK K PHILADELPHIA
KESZELI, MD, ALEXANDER CHESTER
KETELS, MD, ERK A BUCKS
KETTERING, MD, DONALD L WESTMORELAND
KETTRICK, MD, JAMES P H LUZERNE
KETYER, MD, EDWARD C ALLEGHENY
KETZAN, MD, TIBOR ALLEGHENY
KEULER, MD, MARC M LACKAWANNA
KEVENK, MD, KERIM C WESTMORELAND
KEVERLINE, MD, PAUL O WARREN
KEVISH, BARBARA B STUDENT
KEVITCH, MD, ROBERT B LEHIGH
KEYES, MD, BALDWIN L PHILADELPHIA
KEYES, MD, KATHLEEN J ALLEGHENY
KEYKHAH, MD, MOHAMMAD M PHILADELPHIA
KEYS-FREZZELL, MD, DANA J ALLEGHENY
KEYSER, MD, GLENN C DAUPHIN
KEYSER, DO, JEFFREY A LANCASTER
KHADHIRI, MD, DIANA DAUPHIN
KHALAF, MD, KAMAL JEFFERSON
KHALIFA, MD, NAGIB M FRANKLIN
KHALOUF, DO, FRED K BLAIR
KHALUPSKY, MD, LARISA PHILADELPHIA
KHAN, MD, ALI N PHILADELPHIA
KHAN, MD, ANWARULLAH WESTMORELAND
KHAN, MD, IQBAL A PHILADELPHIA
KHAN, SAMEENA S STUDENT
KHAN, MD, SHAUKAT H CARBON
KHAN, MD, SULTAN SCHUYLKILL
KHAN, MD, YASIN N LEHIGH
KHANDAKER, MD, DILARA Z BERKS
KHANNA, MD, OM P PHILADELPHIA
KHANNA, MD, SUDHIR K NORTHUMBERLAND
KHATRI, MD, VIJAY P NORTHAMPTON
KHELLA, MD, HANI J MONTGOMERY
KHELLA, MD, LEWIS PHILADELPHIA
KHELLA, MD, SAMI L PHILADELPHIA
KHERA, MD, DINESH C ERIE
KHIN, MD, KHIN PHILADELPHIA
KHODARAHMI, DONNA J STUDENT
KHOLOUSSY, MD, ABDELMOHSEN M SCHUYLKILL
KHONA, MD, NITHYASHUBA B PHILADELPHIA
KHOORY, MD, MAGED S MONTGOMERY
KHOURY, MD, DENNIS J PHILADELPHIA
KHOURY, MD, JACQUES A DELAWARE
KHUBCHANDANI, MD, INDRU T LEHIGH
KHURANA, MD, RAMESH C ALLEGHENY
KHWAJA, MD, RAHILA S ALLEGHENY
KIBELBEK, MD, MICHAEL J MONTOUR
KIBELSTIS, MD, JOHN A LEHIGH
KICHLER, MD, JOEL M ALLEGHENY
KIEL, MD, STEVEN M DELAWARE
KIESEL, MD, ROBERT LEHIGH
KIEWE, RANDY P STUDENT
KIGHTLINGER, DO, JAMES FAYETTE
KIHM, MD, RONALD H BLAIR
KIKKAWA, MD, KAZUTOSHI BRADFORD
KILCHEVSKY, MD, EITAN S BERKS
KILLIAN, MD, DOROTHEA M MONTGOMERY
KILLIAN, MD, PAUL J ALLEGHENY
KILLIAN III, MD, CALEB L BERKS
KILMORE JR, MD, VANCE E DAUPHIN
KILPATRICK, MD, GERTRUDE E BEAVER
KILPATRICK, MD, WILLIAM F WASHINGTON
KILPATRICK, EXEC SEC, WILLIAM H NORTHAMPTON
KILPELA, MD, DONALD A ALLEGHENY
KIM, MD, ALEXIS H PHILADELPHIA
KIM, ANDREW S STUDENT
KIM, DO, CELL U TIOGA
KIM, MD, CHRISTOPHER Y ALLEGHENY
KIM, MD, CHUNG H LEHIGH
KIM, MD, CHUNG S BERKS
KIM, MD, DAVID K PHILADELPHIA
KIM, DAVID Y STUDENT
KIM, MD, DONG H WESTMORELAND
KIM, MD, DONG H FAYETTE
KIM, MD, DOO T NORTHAMPTON
KIM, MD, EDWARD PHILADELPHIA
KIM, EMERY L STUDENT
KIM, MD, ERICH YORK
KIM, MD, ESTHER M PHILADELPHIA
KIM, MD, EUGENE Y ALLEGHENY
KIM, MD, EUL K LACKAWANNA
KIM, MD, EUNHA PHILADELPHIA
KIM, MD, HACK J LANCASTER
KIM, MD, HI S MONTGOMERY
KIM, MD, HWAN Y CAMBRIA
KIM, MD, HYOUNG D ALLEGHENY
KIM, MD, HYUNG-BAE LUZERNE
KIM, MD, IH C NORTHAMPTON
KIM, MD, IKJIN PHILADELPHIA
KIM, MD, IL G LYCOMING
KIM, MD, IN-SOON BUCKS
KIM, MD, JAE-CHIL ALLEGHENY
KIM, DO, JAMES B MONROE
KIM, MD, JE H LAWRENCE
KIM, MD, JIN I LEHIGH
KIM, MD, JIN R MONTGOMERY
KIM, MD, JUNG S PHILADELPHIA
KIM, MD, KUN H WASHINGTON
KIM, MD, KWAN E PHILADELPHIA
KIM, MD, MYOUNG S FAYETTE
KIM, MD, PATRICIA A STUDENT
KIM, MD, PAUL S CHESTER
KIM, ROY H STUDENT
KIM, MD, RYOMIN ALLEGHENY
KIM, MD, SANG M JEFFERSON
KIM, MD, SCOTT S ALLEGHENY
KIM, MD, SUN C SCHUYLKILL
KIM, MD, SUNG Y ALLEGHENY
KIM, MD, THOMAS A ALLEGHENY
KIM, MD, UH G LAWRENCE
KIM, MD, WAN J LAWRENCE
KIM, MD, WHA S FAYETTE
KIM, MD, WHA SUN ALLEGHENY
KIM, MD, YANG K BUTLER
KIM, MD, YONG DEOK ALLEGHENY
KIM, MD, YONG IL WESTMORELAND
KIM, MD, YOON C ALLEGHENY
KIM, MD, YOUNG B CHESTER
KIM, MD, YOUNG W BUCKS
KIM, MD, YUNG S BUCKS
KIMBALL, MD, C EVE J BERKS
KIMBALL, MD, HARRY R PHILADELPHIA
KIMBALL JR, MD, DANIEL B BERKS
KIMBER, MD, WILLIAM J MONTOUR
KIMBLE, DO, GREGORY A DAUPHIN
KIMELHEIM, DO, ROBERT A MONTGOMERY
KIMLESS-GARBER, MD, DEBRA B DELAWARE
KIMMEL, MD, CRAIG A BERKS
KIMMEL, MD, DEBORAH N LEHIGH
KIMMEL, MD, HENRY A DELAWARE
KIMMEL, MURRAY A STUDENT
KIMMEL, MD, MURRAY H PHILADELPHIA
KIMPEL, MD, BEVERLY A PERRY
KIMPEL, MD, REBECCA I ALLEGHENY
KINDER, MD, ROY R DELAWARE
KING, MD, ANDREW J CAMBRIA
KING, MD, ARTHUR B BRADFORD
KING, MD, ARTHUR H WESTMORELAND
KING, MD, BARBARA L ALLEGHENY
KING, MD, BERNARD D BUCKS
KING, MD, DOUGLAS R CENTRE
KING, MD, JOSEPH T BRADFORD
KING, KATHLEEN S STUDENT
KING, KEVIN J STUDENT
KING, MD, LEO M ALLEGHENY
KING, MD, LOIS I PHILADELPHIA
KING, MD, LORRAINE C PHILADELPHIA
KING, MD, PHILLIP E CAMBRIA
KING, ROBERT C STUDENT
KING, MD, S VICTOR BLAIR
KINGHORN, MD, MILDRED A ALLEGHENY
KINGSBURY, MD, ROBERT C MONTGOMERY
KINLAW, MD, W BERNARD MONTGOMERY
KINNEY, MD, MARY S WESTMORELAND
KINOSIAN, MD, MARY J JEFFERSON
KINSEY, MD, ROBERT H MONTOUR
KINSMAN, MD, SARA B PHILADELPHIA
KINTZEL, MD, JAMES E LEHIGH
KINTZER JR, MD, JOHN S NORTHAMPTON
KINTZI, MD, HARRY E LANCASTER
KIOK, MD, MAXIMO C FAYETTE
KIPP, MD, JAMES E LANCASTER
KIRALY, MD, LASZLO LACKAWANNA
KIRBY, MD, CLAUDE W CAMBRIA
KIRBY, MD, JAMES E YORK
KIRCHDOERFER, MD, ELAINE J SCHUYLKILL
KIRCHER, MD, KIP A PHILADELPHIA
KIRCHHOFER, MD, LEWIS H DELAWARE
KIRCHMANN, MD, TINTIN T PHILADELPHIA
KIRCHNER, MD, G GARY LANCASTER
KIRCHNER, DO, JEFFREY T LANCASTER
KIRK, MD, DANIEL L NORTHMBRLAND
KIRK, MD, MICHAEL D SCHUYLKILL
KIRKER JR, MD, WALTER R DAUPHIN
KIRKLAND, MD, MATT L PHILADELPHIA
KIRKPATRICK, MD, DANIEL W MONTGOMERY
KIRKPATRICK, MD, SAMUEL A YORK
KIRKPATRICK, MD, WILLIAM H PHILADELPHIA
KIRKPATRICK JR, MD, DAVID D CRAWFORD
KIRSCH, MD, PAUL S MCKEAN
KIRSCHBAUM, DO, MICHAEL J PHILADELPHIA
KIRSCHNER, DO, RONALD A MONTGOMERY
KIRSHBAUM, MD, BERNARD A PHILADELPHIA
KIRSHEN, MD, MICHELLE R ALLEGHENY
KIRTLAND III, MD, HOWARD H VENANGO
KISH, MD, GEORGE F ERIE
KISH, DO, JOHN M LUZERNE
KISH, MD, ROBERT S CENTRE
KISH, MD, ZOLTAN L INDIANA
KISLOFF, MD, BARRY ALLEGHENY
KISNER, MD, ROBERT G ALLEGHENY
KISSELL, MD, DEWITT C ALLEGHENY
KISSICK, MD, WILLIAM L PHILADELPHIA
KISTLER, MD, DAVID W LUZERNE
KISTLER, MD, KERMIT K LEHIGH
KISTLER, MEG S STUDENT
KISTLER, MD, PAUL M MONTGOMERY
KISTLER, MD, PHILIP E CHESTER
KISTLER, MD, PRISCILLA J MONTGOMERY
KISTLER, MD, WARREN D FRANKLIN
KISTLER, MD, WILLIAM S MONTGOMERY
KITAY, MD, KALEEN PHILADELPHIA
KITAY, MD, STEVEN E STUDENT
KITCHEN II, MD, JAMES G MONROE
KITCHEN III, MD, JAMES G DELAWARE
KITEI, MD, MILTON N PHILADELPHIA
KITEI, MD, WILLIAM J NORTHAMPTON
KITSKO, DO, DENNIS WASHINGTON
KITSKO, MD, WILLIAM T CAMBRIA
KITSON, JOANNE STUDENT
KITTLEBERGER, MD, WILLIAM C BUCKS
KITZMILLER, MD, JOHN K DAUPHIN
KIVITZ, MD, ALAN J BLAIR
KLAG, DO, JOSEPH V BEAVER
KLAIN, MD, MATTHEW N ALLEGHENY
KLAIN, MD, MIROSLAV ALLEGHENY
KLASKIN, DO, BRUCE D YORK
KLASKO, MD, STEPHEN K LEHIGH
KLASS, MD, DANIEL J PHILADELPHIA
KLATCHKO, MD, BARBARA A MONTGOMERY
KLATCHKO, MD, WILLIAM W LEBANON
KLATMAN, MD, SAMUEL J ALLEGHENY

KLAUS, MD, THOMAS C ERIE
KLAUSNER, MD, ROBERT D PHILADELPHIA
KLAVAN, MD, MARSHALL DELAWARE
KLAWON, MD, DAVID L ERIE
KLAY, MD, JOHN W ALLEGHENY
KLEAVELAND, MD, JOSEPH P LEHIGH
KLECKNER, MD, FRANCIS S LEHIGH
KLEEMAN, MD, AUDREY K BUCKS
KLEES, MD, ATHANASIUS LEHIGH
KLEES, DO, DAVID A ERIE
KLEES, MD, JULIA E PHILADELPHIA
KLEIDERMACHER, PAUL STUDENT
KLEIN, MD, ALBERT ALLEGHENY
KLEIN, MD, DAVID A BUCKS
KLEIN, MD, DOROTHY E PHILADELPHIA
KLEIN, MD, FRED S WASHINGTON
KLEIN, MD, JOSEPH F CHESTER
KLEIN, MD, JOSEPH M LUZERNE
KLEIN, MD, LAWRENCE MONROE
KLEIN, MD, MARDECAI N ALLEGHENY
KLEIN, MD, MICHAEL A YORK
KLEIN, MD, MICHAEL E DAUPHIN
KLEIN, DO, MILTON J ALLEGHENY
KLEIN, MD, RAYMOND A DELAWARE
KLEIN, MD, RICHARD M ALLEGHENY
KLEIN, MD, SHELDON PHILADELPHIA
KLEIN, MD, THEODORE C JEFFERSON
KLEIN, MD, THOMAS E DELAWARE
KLEIN JR, MD, WILLIAM J BERKS
KLEINBART, JENNIFER M STUDENT
KLEINBART, MD, MORRIS PHILADELPHIA
KLEINER, MD, ANTON J BERKS
KLEINER, MD, HENRY T PHILADELPHIA
KLEINER, MD, ROBERT C PHILADELPHIA
KLEINERT, MD, RICHARD W CLEARFIELD
KLEINMAN, DO, JAY M NORTHAMPTON
KLEINSCHMIDT, MD, ROBERT F ALLEGHENY
KLEM, MD, ALBERT J LUZERNE
KLEMENS, MD, ROBERT F CAMBRIA
KLEPPEL, MD, JUDY PHILADELPHIA
KLEPPINGER, MD, RICHARD K BERKS
KLETTER, MD, JAN C SUSQUEHANNA
KLIEGER, MD, HERMAN L WESTMORELAND
KLIGERMAN, MD, MORTON M PHILADELPHIA
KLIGMAN, MD, ALBERT M PHILADELPHIA
KLIMES, MD, RONALD L YORK
KLINE, MD, EDGAR W MONTGOMERY
KLINE, DO, GLENN A LANCASTER
KLINE, MD, IRWIN K DELAWARE
KLINE, MD, JACK A YORK
KLINE, MD, MATTHEW T PHILADELPHIA
KLINE, MD, MICHAEL R PHILADELPHIA
KLINE, MD, ROBERT M LEBANON
KLINE, MD, ROBERT W ALLEGHENY
KLINE, MD, TILDE S DELAWARE
KLINEFELTER, MD, HYLDA C DELAWARE
KLINGENSMITH, MD, MARK R MONTOUR
KLINGENSMITH, MD, WALTER C PHILADELPHIA
KLINGER, MD, FRANK A VENANGO
KLINGER, MD, HARRY M MONTOUR
KLINGHOFFER, MD, JUNE F PHILADELPHIA
KLINGHOFFER, MD, LEONARD PHILADELPHIA
KLINMAN, MD, STEVEN W PHILADELPHIA
KLINMAN, MD, WILLIAM PHILADELPHIA
KLINOW, MD, LINDA F DELAWARE
KLINZING, MD, GERARD F DELAWARE
KLIONSKY, MD, BERNARD L ALLEGHENY
KLOIN, MD, JAY E LEHIGH
KLOMBERS, MD, LEE A BERKS
KLOS, JULIAN W STUDENT
KLOSE, MD, PAUL L SOMERSET
KLOTZ, MD, DONALD J LEHIGH
KLUFAS, MD, ALEXANDER J CHESTER
KLUFT, MD, RICHARD P PHILADELPHIA
KLUG, MD, GERALD D ALLEGHENY
KLUTZ, MD, JOSEPH P ALLEGHENY
KMETZO, MD, JAMES J BUCKS
KNAPP, MD, MICHAEL A BUCKS
KNAPP, MD, ROBERT C BEAVER
KNAPPENBERGER, MD, GEORGE F ALLEGHENY
KNAPPER, MD, ELIZABETH J LEHIGH
KNAUB, MD, MARILYN B LANCASTER
KNAUBER, MD, SUSAN A STUDENT
KNAUSS-BROWN, CHRISTINA C STUDENT
KNECHT, MD, CHARLES L LEHIGH
KNEE, DO, NORMAN S PHILADELPHIA
KNEIFATI, MD, AHMED NORTHMBRLAND
KNEPLEY, MD, DAVID W COLUMBIA
KNEPP, MD, ELIZABETH E ALLEGHENY
KNEPPER, MD, JOSEPH A LANCASTER
KNEPPER, MD, LAURIE E ALLEGHENY
KNERR, MD, RICHARD A CENTRE
KNERR JR, MD, EDGAR D LANCASTER
KNIAZER, MD, BARRY BERKS
KNIGHT, ADINA K STUDENT
KNIGHT, MD, BARBARA S PHILADELPHIA
KNIGHT JR, MD, EMERSON L DAUPHIN
KNOCH, MD, H ROEBLING YORK
KNOLL, MD, GEORGE M NORTHAMPTON
KNORR, ERIC J STUDENT
KNOTT, MD, ALBERT P ALLEGHENY
KNOUSE, MD, ALBERT B BUCKS
KNOUSE, MD, MARK C LEHIGH
KNOWLES, MD, HARRY J PHILADELPHIA
KNOWLES, SHELLEY R STUDENT
KNOWLES, MD, WILLARD E DELAWARE
KNOX JR, MD, JAMES D CHESTER
KNOX-LEE, DO, MARGARET M LANCASTER
KNUPP, MD, DONNA L ALLEGHENY
KNUPP, MD, MELVIN L DAUPHIN
KO, ALBERT E STUDENT
KO, MD, CHAN S SCHUYLKILL
KO, MD, EUGENE C H LANCASTER
KO, MD, MICHAEL D PHILADELPHIA
KO, MD, MIN-HSIUNG PHILADELPHIA
KO, MD, YIH-SHYONG CARBON
KO, MD, YIH-SONG MERCER
KOBALY, MD, DAVID J ALLEGHENY
KOBAN, MD, JAMES M DAUPHIN
KOCAN, MD, RICHARD S ERIE
KOCH, MD, ANDREW W LANCASTER
KOCH, MD, JOSEPH C NORTHAMPTON
KOCH, MD, L VON LACKAWANNA
KOCH, MD, PAMELA J LANCASTER
KOCH, ROBERT M STUDENT
KOCH, MD, THOMAS J LEHIGH
KOCHAR, MD, GURPREET S PHILADELPHIA
KOCHU, MD, STEVE BERKS
KODALI, MD, RAJA V ALLEGHENY
KODSI, MD, MAGDI S PHILADELPHIA
KODUMAL, MD, LUIS E DELAWARE
KOEHL JR, MD, C WARREN LUZERNE
KOELLER, MD, ROYAL R CAMBRIA
KOELSCH, MD, ROBERT R BUCKS
KOENIG, MD, JOHANN A LUZERNE
KOENIG, MD, MARK A ALLEGHENY
KOENIG, MD, THEODORE R CLARION
KOEPSELL, MD, DON G CHESTER
KOERBER JR, MD, WALTER A DAUPHIN
KOFELDT, LINDA M STUDENT
KOFF, MD, RICHARD A BUCKS
KOFINAS, MD, ALEXANDER D YORK
KOFOS, DANNY M STUDENT
KOFSKY, MD, PHILLIP M MONTGOMERY
KOH, MD, ENRIQUE S CAMBRIA
KOH, MD, JEANMARIE J A CAMBRIA
KOHAN, DO, DAVID A LEHIGH
KOHL, MD, DAVID H ARMSTRONG
KOHL, MD, E JAMES PHILADELPHIA
KOHL, MD, STEPHEN D BERKS
KOHLER, EXEC SEC, MICHAEL P CAMBRIA
KOHLHAS, MD, JACOB J MONTGOMERY
KOHLMEIER, MD, RUTH E ALLEGHENY
KOHN, MD, IRA J MONTGOMERY
KOHN, MD, MARK I PHILADELPHIA
KOHRT, MD, ALAN E WAYNE/PIKE
KOHUT, DO, PAUL A ERIE
KOHUTIAK, MD, VSEVOLOD DELAWARE
KOIMATTUR, MD, ARWIND ALLEGHENY
KOIWAI, MD, EICHI K PHILADELPHIA
KOKALES, MD, JOHN G ALLEGHENY
KOKOTOS, FOTINI J STUDENT
KOLANSKY, MD, HAROLD PHILADELPHIA
KOLB, MD, AARON J LYCOMING
KOLB, MD, CHARLES E LYCOMING
KOLBER, MD, LAUREN R BUCKS
KOLLER, MD, HAROLD P MONTGOMERY
KOLLI, MD, RAVINDRANATH ALLEGHENY
KOLLMAN, MD, DALE R CLARION
KOLLMAR JR, JAMES J STUDENT
KOLMEN, MD, BARBARA K ALLEGHENY
KOLONICH, MD, KIMBERLY A MIFFLIN/JUNI
KOLOVOS, NIKOLETA S STUDENT
KOLTER, MD, JAMES S CHESTER
KOLTER JR, MD, JOSEPH P ALLEGHENY
KOLTES, MD, JOHN A PHILADELPHIA
KOLTON, MD, VLADIMIR J BERKS
KOLUCKI, MD, FRANK R LACKAWANNA
KOMAN, CHRISTOPHER G STUDENT
KOMAR, MD, MICHAEL J MONTOUR
KOMEN, MD, SUPOTE S WASHINGTON
KOMER, MD, LOUIS M ALLEGHENY
KOMINSKY, MD, ALAN H PHILADELPHIA
KONCHANIN, MD, LYNN M BUCKS
KONCHANIN, MD, RONALD P BRADFORD
KONCHAR, MD, WILLIAM C MONTOUR
KONDAMURI, MD, SAVEEN K ALLEGHENY
KONDASH, DO, DENNIS J LACKAWANNA
KONDASH, DO, MICHAEL L LACKAWANNA
KONDAVEETI, MD, KOTAYYA ALLEGHENY
KONDRATOWSKI, MD, RICHARD Z PHILADELPHIA
KONDROT, MD, EDWARD C ALLEGHENY
KONECKE, MD, LEE L MONTGOMERY
KONECKE, MD, M LOUIS LUZERNE
KONHAUS, MD, CAROL H DAUPHIN
KONIGES, MD, FRANK C DELAWARE
KONRAD, MD, MARK G BEAVER
KONTRA, MD, JOSEPH M LANCASTER
KONVOLINKA, MD, CARL W BRADFORD
KOO, MD, KIM ENG PHILADELPHIA
KOO, MD, WOOK H LUZERNE
KOOBATIAN, MD, THOMAS J PHILADELPHIA
KOOLPE, MD, HARVEY A PHILADELPHIA
KOOLPE, MD, LOUIS PHILADELPHIA
KOOPMAN, PETER J STUDENT
KOOROS, MD, KIAN S ALLEGHENY
KOOSER, MD, ROBERT R ALLEGHENY
KOPEN, MD, DAN F LUZERNE
KOPENHAVER, MD, DONALD B LEHIGH
KOPERA, MD, KEVIN W ALLEGHENY
KOPPEL, ADAM M STUDENT
KOPPELMAN, GAYLE M STUDENT
KOPROWSKI, MD, HILARY PHILADELPHIA
KOPYT, DO, NELSON P LEHIGH
KORB, MD, LEROY J ERIE
KORBONITS, MD, CHARLES W CHESTER
KORENTZWITT, MD, EDITH PHILADELPHIA
KOREY, MD, JOSEPH J PHILADELPHIA
KOREY JR, MD, JOSEPH J BERKS
KORHAMMER, MD, ALAN F NORTHAMPTON
KORINCHAK, MD, JEROME L MIFFLIN/JUNI
KORNELUK-REILLY, MD, THERESA PHILADELPHIA
KORNFIELD, MD, NORMAN S LANCASTER
KORNIENKO, MD, WALTER A DELAWARE
KOROSI, ANTHONY F STUDENT
KORT, MD, JOSEPH F NORTHMBRLAND
KORZENLOWSKI, MD, PHILIP A PHILADELPHIA
KOSAR, MD, EROL M ALLEGHENY
KOSCO, MD, GEORGE M JEFFERSON
KOSCO III, DO, GEORGE M DAUPHIN
KOSENKO, MD, ALEXANDER ERIE
KOSHAR, MD, MARK I NORTHAMPTON
KOSHINSKI, DO, RITA S PHILADELPHIA
KOSIEROWSKI, MD, RICHARD R BUCKS
KOSLOW, MD, SUSAN A ALLEGHENY
KOSSOL, MD, JANET M ALLEGHENY
KOST, MD, KENNETH R ARMSTRONG
KOST, MD, PAUL F ALLEGHENY
KOSTER, MD, LEE H WESTMORELAND
KOSTYAL, MD, JOHN L ALLEGHENY
KOTAKE, SUSAN STUDENT
KOTAKIS, MD, JOHN PHILADELPHIA
KOTCH, INGRID E STUDENT
KOTCH, MD, MICHAEL J LUZERNE
KOTCHICK, MD, E DONALD LACKAWANNA
KOTHAPALLI, MD, SRINIVASA R MONTGOMERY
KOTLER, MD, BARRY M PHILADELPHIA
KOTLOFF, MD, LEON PHILADELPHIA
KOTLOFF, MD, ROBERT M PHILADELPHIA
KOTSENAS, AMY L STUDENT
KOTTAPALLY, MD, SRINIVAS M ALLEGHENY
KOTTNER JR, MD, WILLIAM W WASHINGTON
KOTWAL, MD, NEVILLE H PHILADELPHIA
KOTWAL, MD, NIRMAL D ALLEGHENY
KOTYO, MD, JOHN A DELAWARE
KOUGH, MD, ROBERT H MONTOUR
KOUKAL, MD, LUDWIG R LAWRENCE
KOUSEN, MD, MORTON YORK
KOUTCHER, MD, MARTIN E PHILADELPHIA
KOVAL, MD, JOSEPH C LACKAWANNA
KOVALOVICH, ASHA STUDENT
KOVALSKI, MD, RAYMOND CHESTER
KOVALSKY, MD, DON A PHILADELPHIA
KOVALSKY, MD, EVAN S MONTGOMERY
KOVALSKY, MD, KENNETH BERKS
KOVAR, MD, CHARLES E NORTHAMPTON
KOVATCH, MD, ANTHONY L ALLEGHENY
KOVATS, MD, ENIKO A PHILADELPHIA
KOVEN, MD, NORMAN L PHILADELPHIA
KOWAL, MD, CATHERINE N PHILADELPHIA
KOWALCHUK, ROMAN M STUDENT
KOWALLIS, MD, GEORGE F ALLEGHENY
KOWALSKI, MD, LYNN D ALLEGHENY
KOWALYSHYN, MD, MICHAEL J BUCKS
KOWTONIUK, DO, CAROL E CAMBRIA
KOZAKIEWICZ, RICHARD T STUDENT
KOZART, MD, DAVID M PHILADELPHIA
KOZERA, MD, RICHARD J PHILADELPHIA
KOZIN, MD, WILLIAM DELAWARE
KOZINN, MD, WESLEY P NORTHAMPTON
KOZLEK, MD, THOMAS F LUZERNE
KOZLOSKI, MD, MAUREEN C LACKAWANNA
KOZLOWSKI, DO, MARYANN ERIE
KOZMINSKY, MD, MARK E CENTRE
KOZUB, MD, ROBERT E PHILADELPHIA
KRABLIN, MD, RONALD ADAMS
KRACHMAN, DO, BRIAN S MONTGOMERY
KRACKOW, MD, JOEL A DELAWARE
KRAFCHIN, MD, IRA C LACKAWANNA
KRAFT, WALTER K STUDENT
KRAFT JR, MD, ALBERT J MONTGOMERY
KRAFT-DEBRAKELEER, DO, LYNNE M DELAWARE
KRAFTOWITZ, MD, ROBERT E ALLEGHENY
KRAH, EXEC DIR, JOHN G ALLEGHENY
KRAIN, MD, RAYMOND DELAWARE
KRAINSKY, MD, SAMUEL M PHILADELPHIA
KRAJESKI, MD, R DREW BUCKS
KRAK, MD, MICHAEL ALLEGHENY
KRAKOVITZ, MD, JAY A PHILADELPHIA
KRALJEVIC, MD, JUAN E BERKS
KRALL, MD, J THOMAS DELAWARE
KRALSTEIN, MD, JEFFREY R LEHIGH
KRAM, MD, JOHN E ALLEGHENY
KRAMER, MD, ARNOLD LUZERNE
KRAMER, MD, DAVID J PHILADELPHIA
KRAMER, MD, FREDERICK L PHILADELPHIA
KRAMER, GARY S STUDENT
KRAMER, DO, JOEL R MONTGOMERY
KRAMER, MD, KENNETH NORTHAMPTON
KRAMER, MD, MARK S PHILADELPHIA
KRAMER, RACHEL L STUDENT
KRAMER, MD, ROBERT E CAMBRIA
KRAMER, RYAN M STUDENT
KRAMER, MD, SELMA PHILADELPHIA
KRAMER, MD, SHERRI L PHILADELPHIA
KRAMER, MD, SIMON PHILADELPHIA
KRAMER, MD, WILLIAM A FRANKLIN
KRAMER JR, MD, PAUL R DAUPHIN
KRANE, MD, BARRY D DAUPHIN
KRANE, MD, MARVIN A PHILADELPHIA
KRANIK, MD, ANDREW D ALLEGHENY
KRANTZ, MD, KATHRYN E PHILADELPHIA
KRANTZ, MORI J STUDENT
KRANTZ, MD, WALTER J MONTGOMERY
KRANTZLER, MD, JOSEPH D MONTGOMERY
KRANZ, MD, ARTHUR J MONTGOMERY
KRARAS, MD, CHRISTINE M PHILADELPHIA
KRASNOFF, MD, SIDNEY O PHILADELPHIA
KRATZ, DO, LEO YORK
KRATZ, RICHARD T STUDENT
KRATZ, MD, RONALD D DAUPHIN
KRATZ, MD, VERNON H BUCKS
KRATZER, MD, GUY L LEHIGH
KRAULAND, MD, JOHN E CAMBRIA
KRAUS, MD, DAVID R ALLEGHENY
KRAUS, MD, JOHN F FAYETTE
KRAUS, MD, JOHN J CHESTER
KRAUS, MD, RICHARD E YORK
KRAUS, MD, THEODORE J PHILADELPHIA
KRAUSE, DO, CRAIG J SCHUYLKILL
KRAUSE, MD, HELEN F ALLEGHENY
KRAUSE, MD, MARILYN PHILADELPHIA
KRAUSE, MD, NORMAN M ALLEGHENY
KRAUSE, MD, ROBERT E LACKAWANNA
KRAUSE, MD, ROBERT L PHILADELPHIA
KRAUSE, MD, SEYMOURE ALLEGHENY
KRAUSER, MD, RONALD E CHESTER
KRAUSZ, MD, MARTIN R PHILADELPHIA
KRAVIS, MD, LILLIAN P MONTGOMERY
KRAVITZ, MD, BERNARD J MONTGOMERY
KRAVITZ, MD, CHARLES H PHILADELPHIA
KRAVITZ, MD, JOHN J BUCKS
KRAVITZ, MD, KEVIN D PHILADELPHIA
KRAWET, MD, STEVEN H PHILADELPHIA
KRAWITZ, MD, PAUL L BERKS
KRAYBILL, MD, HAROLD E LEBANON
KRAYBILL, MD, LEON S LANCASTER
KRAYER JR, MD, NICHOLAS H BEAVER
KRAYNACK, MD, BARRY J BERKS
KRAYNICK, MD, BENJAMIN M LEHIGH
KREBS, MD, JAMES A ALLEGHENY
KREBS, MD, STEPHEN J CUMBERLAND
KREEL, MD, BARBARA J LUZERNE
KREGER, MD, SPENCER CAMBRIA
KREIDER, MD, EDWARD E LEBANON
KREIDER, MD, HENRY L LANCASTER
KREIDER, MD, JOHN K LANCASTER
KREIDER, MD, JOHN W DAUPHIN
KREIDER, MD, KATHLEEN A LANCASTER
KREINBROOK, MD, SUZANNE B ALLEGHENY
KREITHEN, MD, HAROLD LEHIGH
KRELL, MD, ARTHUR S CAMBRIA
KREMENS, MD, VICTOR PHILADELPHIA
KREMER, MD, FREDERIC B PHILADELPHIA
KREMER, MD, HOWARD U PHILADELPHIA
KREMER JR, MD, EDWIN S ERIE
KREMSER, MD, CHARLES A ALLEGHENY
KRENZEL, MD, ARCHIBALD R PHILADELPHIA
KRESH, MD, NORMAN N ALLEGHENY
KRESOCK JR, MD, FRANK D COLUMBIA
KRESPAN, MD, CHARLES B LANCASTER
KRESSLER, MD, ROBERT J PHILADELPHIA
KRESSLY, MD, SUSAN J BUCKS
KRETZING, MD, HAROLD G CUMBERLAND
KREULEN, MD, THOMAS H PHILADELPHIA
KREUZBURG, MD, ROBERT C COLUMBIA
KRICK, MD, ANDREW E BUCKS
KRIDGEN, MD, PAMELA L ALLEGHENY
KRIEBEL, MD, DOROTHY E BERKS
KRIEBEL, MD, RICHARD H BUCKS
KRIEDMAN, MD, TERRY F PHILADELPHIA
KRIEGER, MD, BENSON PHILADELPHIA
KRIEGER, MD, HARRY L NORTHAMPTON
KRIFCHER, MD, CHARLES ALLEGHENY
KRIFCHER, MD, EMANUEL ALLEGHENY
KRING, MD, CARROLL S BERKS
KRIPALANI, MD, ASHA G ALLEGHENY
KRIPKE, MD, SCOTT A CHESTER
KRISANDA, MD, JOSEPH B LACKAWANNA
KRISCH, MD, RONALD A LEHIGH
KRISHNA, MD, BHUPENDRA CHESTER
KRISHNA, MD, NARENDRA CHESTER
KRISHNAN, MD, GEETA COLUMBIA
KRISHNAN, MD, KALYAN S MONTOUR
KRISHNAN, MD, R G WASHINGTON
KRISHNAN, MD, SHANTI CHESTER
KRISHNAPPA, MD, BORIAH N WESTMORELAND
KRISHNASWAMI, MD, SUBRAMANIA ALLEGHENY
KRISHNASWAMI, MD, V ALLEGHENY
KRISSINGER, MD, ROBERT C LANCASTER
KRISTOFIC, MD, JOHN D ALLEGHENY
KRISTOFICH, MD, JOHN P LEHIGH
KRIVENKO, MD, CHARLES A LUZERNE
KRIVINKO, MD, DENNIS M ALLEGHENY
KRIVY, MD, JULIE B PHILADELPHIA
KROGER, MD, JOHN E LANCASTER
KROHN, MD, KELLY D ALLEGHENY
KROHNER, DO, ROBERT G ALLEGHENY
KROL, MD, RONALD C BERKS
KROLL, MD, BARRY S STUDENT
KROMASH, MD, MARVIN H MONTGOMERY
KRON, MD, KENNETH M PHILADELPHIA
KRON, MD, SAMUEL D PHILADELPHIA
KRONENWETTER, MD, CHRISTOPHER A ELK/CAMERON
KRONENWETTER, MD, LOIS A LANCASTER
KROOP, MD, HOWARD S PHILADELPHIA
KROPINICKI, MD, WILLIAM C BUCKS
KROSER, MD, JOYANN A PHILADELPHIA
KROSER, MD, LILA S PHILADELPHIA
KROSNOFF, MD, MICHAEL WASHINGTON
KROSS, MD, DEAN E ALLEGHENY
KROTEC, MD, JOSEPH W ALLEGHENY
KROUNER, MD, ANDREW D ALLEGHENY
KROUSE, MD, JOHN M WESTMORELAND
KROUSE, MD, THEODORE B PHILADELPHIA
KROUSKOP, MD, ANDREW C ALLEGHENY
KRUCZEK, MD, MICHAEL W BEAVER
KRUG, MD, EDGAR S CENTRE
KRUGH, MD, FRANCIS J ALLEGHENY
KRUGH, MD, JAMES W ALLEGHENY

KRUMMEL, MD, THOMAS M DAUPHIN
KRUPER, MD, JOHN S YORK
KRUSEN, MD, DAVID E LANCASTER
KRUSZEWSKI, DO, DAVID M ERIE
KRYSINSKI, TERRANCE R STUDENT
KRYSTON JR, DO, JOHN J LUZERNE
KRYWICKI, MD, WILLIAM J LUZERNE
KRZEMINSKI, MD, JOSEPH P MONTGOMERY
KRZYWICKI, MD, PAUL L PHILADELPHIA
KUBACKI, MD, JOSEPH J BERKS
KUBER, MD, MATTHEW E PHILADELPHIA
KUBER, MD, MATTHEW T WAYNE/PIKE
KUBICHEK, MD, MARILYN A MONTGOMERY
KUBIK, MD, CAROLYN J ALLEGHENY
KUBIT, VICTOR F STUDENT
KUCER, MD, FRANK T BUCKS
KUCER, MD, KATHLEEN A BUCKS
KUCERA, MD, RICHARD F WESTMORELAND
KUCHARCZUK, MD, JOHN B LEHIGH
KUCHARCZUK, JOHN C STUDENT
KUCHEMBA, MD, LEONARD A LUZERNE
KUDVA, MD, VIDYA B ERIE
KUEHNER, DO, P DENIS LEHIGH
KUEHNER III, WILLIAM P STUDENT
KUGACZEWSKI, MD, JANE T PHILADELPHIA
KUHAR, MD, KIM P PHILADELPHIA
KUHLENGEL, MD, BARBARA G DAUPHIN
KUHLENGEL, MD, KEITH R DAUPHIN
KUHN, MD, MARK D BUCKS
KUHN, MD, RICHARD H ERIE
KUHNEN, MD, WALTER H WARREN
KUHNERT, MD, PAUL M MONTGOMERY
KUHNS, MD, STACEY J YORK
KUKLINSKI, MD, LAWRENCE M ERIE
KUKORA, MD, JOHN S MONTGOMERY
KUKRIKA, MD, MIODRAG D YORK
KULBASKI, MD, FRANK E LUZERNE
KULCZYCKI, MD, EDWARD BRADFORD
KULICK, MD, GEORGE SCHUYLKILL
KULKARNI, MD, PRADEEP K CAMBRIA
KUMAR, MD, ASHOK WASHINGTON
KUMAR, MD, HARINATH V VENANGO
KUMAR, MD, PRADEEP WESTMORELAND
KUMAR, MD, PREM BUTLER
KUMAR, MD, RAKESH ALLEGHENY
KUMAR, MD, VEERANDRA PHILADELPHIA
KUN, MD, JOSEPH ALLEGHENY
KUNDA, MD, GOPAL D WESTMORELAND
KUNDU, MD, SAMBHU N DAUPHIN
KUNIS, MD, CHRIS C W FRANKLIN
KUNKEL, MD, BARBARA K DAUPHIN
KUNKEL, MD, FRANK A BLAIR
KUNKEL, MD, GEORGE W DAUPHIN
KUNKEL, MD, HERBERT G ALLEGHENY
KUNKEL, MD, JAMES V ALLEGHENY
KUNKEL, MD, MARY E FAYETTE
KUNKEL, REBECCA L STUDENT
KUNKEL, MD, W MINSTER DAUPHIN
KUNKEL, MD, WILLIAM H ALLEGHENY
KUNKEL JR, MD, HERBERT G ALLEGHENY
KUNSCHNER, MD, ALAN J ALLEGHENY
KUNSCHNER, MD, ALBERT J ALLEGHENY
KUNSMAN, MD, WILLIAM E ALLEGHENY
KUNZ, MD, HAROLD G LEHIGH
KUNZ, MD, ROBERT A DELAWARE
KUO, BRADEN STUDENT
KUO, SHEREE STUDENT
KUPERMAN, MD, JULIO L PHILADELPHIA
KUPERSMITH, MD, STEPHEN J BUCKS
KUPFER, MD, SAMUEL ALLEGHENY
KUPFERBERG, STEPHEN B STUDENT
KUPREVICH, DO, WILLIAM J COLUMBIA
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KURELLO, MD, PHILIP J LUZERNE
KUREMSKY, MD, DALE A ALLEGHENY
KUREY, PAMELA H STUDENT
KUREY, MD, ROBERT J LANCASTER
KURIAN, MD, SANTHAMMA BLAIR
KURIC, MD, KEVIN M ERIE
KURJANOWICZ, MD, WADIM BERKS
KUROKI, MD, HELEN M PHILADELPHIA
KURTH, MD, CHARLES D PHILADELPHIA
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KURTZ, MD, ALFRED B PHILADELPHIA
KURTZ, CHRISTOPHER A STUDENT
KURTZ, MD, J STEPHEN PHILADELPHIA
KURTZ, MD, JAMES W CHESTER
KURTZ, MD, JOHN E ALLEGHENY
KURTZ, MD, MICHAEL B DELAWARE
KURTZ, MD, ROBERT M DELAWARE
KURTZ, MD, ROSA T DELAWARE
KURZ, MD, RICHARD B YORK
KURZ, MD, SUSAN D YORK
KURZWEIL, MD, STEVEN J LUZERNE
KUSH, MD, FRANK H ALLEGHENY
KUSH, MD, MARGARET B ALLEGHENY
KUSH, MD, MICHAEL J JEFFERSON
KUSHEL, MD, STEVEN M PHILADELPHIA
KUSHNER, MD, BERTRAND DAUPHIN
KUSHNER, MD, LOIS N YORK
KUSHNER JR, MD, GEORGE YORK
KUSIAK, MD, JOSEPH F PHILADELPHIA
KUSIAK, MD, VICTORIA M PHILADELPHIA
KUSKIN, MD, LOUIS F DAUPHIN
KUSSMAUL, MD, WILLIAM G BERKS
KUTCH, MD, JAMES D WAYNE/PIKE
KUTNER, MD, BARRY N BUCKS
KUTNEY, MD, FRANCIS G DELAWARE
KUTSCHER, MD, HARLAN A BERKS
KUTSENKOW, MD, MICHAEL ALLEGHENY
KUTTY, MD, AHMED C PHILADELPHIA
KUTZ, MD, CHARLES M CLARION
KUTZ, MD, EUGENE R BEDFORD
KUTZ, MD, TIMOTHY J BERKS
KUWIK, MD, RICHARD J ALLEGHENY
KUZMA JR, MD, PAUL M BEAVER
KWA, MD, DANIEL M PHILADELPHIA
KWIAT, MD, MICHAEL A BEAVER
KWON, MD, JONG D BLAIR
KWONG, MD, SHUN C BRADFORD
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KYNE, MD, PETER J ALLEGHENY
KYREAGES, MD, CONSTANTINE G ALLEGHENY
KYRIACOPOULOS, MD, JOHN D ALLEGHENY

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LA CAPRA, MD, SAMUEL PHILADELPHIA
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LACHMAN, MD, JOSEPH DELAWARE
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LALLA, MD, SUNIL N ALLEGHENY
LALLI, MD, JOANNE M LYCOMING
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LALLY, MD, MICHAEL E ALLEGHENY
LALLY, MD, PATRICK T WESTMORELAND
LALOS, MD, ALEXANDER T BRADFORD
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LAMADE, MD, CHARLES D LYCOMING
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LAMANNA, MD, JOHN V BERKS
LAMARQUE, MD, EDWARD E DAUPHIN
LAMAS, MD, CARLOS C ERIE
LAMB, MD, KATHLEEN G ALLEGHENY
LAMBE, HELEN A STUDENT
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LAMBERT, MD, ROBERT L PHILADELPHIA
LAMBERTI, MD, WILLIAM F LACKAWANNA
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LAME, MD, EDWIN L PHILADELPHIA
LAMMENDOLA-MELONE, DO, ANNAMARIE C DELAWARE
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LAMP, MD, ALBERT L ERIE
LAMP JR, MD, CLYDE S ALLEGHENY
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LAMPE II, MD, WILLIAM T YORK
LAMPERSKI, MD, BRENDAN D ALLEGHENY
LAMSBACK, MD, EDWARD G PHILADELPHIA
LAN, MD, VICTOR S INDIANA
LANAUZE, MD, HARRY E ALLEGHENY
LANCASTER, MD, STEWART L BEAVER
LANCASTER JR, MD, EDWARD L LANCASTER
LANDAU, MD, LEO W LUZERNE
LANDAU, MD, PHILIP M ALLEGHENY
LANDAU, MD, RICHARD E MONTGOMERY
LANDAY, MD, LOUIS H ALLEGHENY
LANDAY, MD, RONALD A ALLEGHENY
LANDER, MD, JEFFREY R YORK
LANDER, MD, WILLIAM W MONTGOMERY
LANDERMAN, MD, NATHANIEL S ALLEGHENY
LANDES, MD, RAY P BUCKS
LANDFAIR, MD, ROY J ALLEGHENY
LANDIS, MD, DARRYL L LANCASTER
LANDIS, MD, FLOYD M LANCASTER
LANDIS, MD, JONATHAN C ALLEGHENY
LANDIS, MD, RAY L WYOMING
LANDIS, MD, ROBERT C YORK
LANDIS, MD, TIMOTHY D ALLEGHENY
LANDIS, MD, WILLIAM A YORK
LANDON, BRUCE E STUDENT
LANDON JR, MD, LYNDON H ALLEGHENY
LANE, MD, BARBARA BUCKS
LANE, MD, C DARRELL BERKS
LANE, MD, JOHN D BUCKS
LANE, MD, JOHN F WASHINGTON
LANE, MD, SALLY D PHILADELPHIA
LANERI, MD, GIOVANNI ALLEGHENY
LANFORD, MD, LIZABETH M ALLEGHENY
LANG, MD, DAVID F ALLEGHENY
LANG, MD, GREGORY M LEHIGH
LANG, MD, HOWARD N ALLEGHENY
LANG, DO, JOHN B NORTHAMPTON
LANG, MD, NIKKI PHILADELPHIA
LANG, MD, STANLEY JEFFERSON
LANGA, MD, VICTORIA M ALLEGHENY
LANGANKE, MD, E LAWRENCE DELAWARE
LANGDON, MD, DAVID R MONTOUR
LANGE, MD, MARIANNE K NORTHAMPTON
LANGE JR, MD, PAUL C ALLEGHENY
LANGER, MD, BURTON H MONTGOMERY
LANGER, MD, D MORTON YORK
LANGER, MD, TERRY PHILADELPHIA
LANGIERI, MD, GARY PHILADELPHIA
LANGLEBEN, MD, DANIEL D PHILADELPHIA
LANGOL JR, MD, GEORGE ALLEGHENY
LANGON, MD, JAMES SCHUYLKILL
LANGRALL, MD, HARRISON M CHESTER
LANIGAN, MD, CHRISTINE J PHILADELPHIA
LANNING, MD, RICHARD C DAUPHIN
LANOCE, MD, LOUIS F PHILADELPHIA
LANPHER, MD, GREGORY B YORK
LANSING, MD, DOROTHY I CHESTER
LANTZY, MD, ALAN ALLEGHENY
LANZ, MD, RICHARD K ALLEGHENY
LANZ JR, MD, ROBERT J ALLEGHENY
LANZA, MD, DONALD C PHILADELPHIA
LANZA, MD, RALPH A CHESTER
LANZI, RICHARD A STUDENT
LANZILLO, MD, JOSEPH H LANCASTER
LAPAT, MD, RICHARD C PHILADELPHIA
LAPAYOWKER, MD, MARC S PHILADELPHIA
LAPE JR, MD, I SAMUEL LEBANON
LAPERLE, MD, MARGARET M STUDENT
LAPES, MD, GEORGE A YORK
LAPORTA, MD, EDWARD W DELAWARE
LAPORTE, MD, PATRICK J MONTOUR
LAPORTE, MD, STEVEN M CHESTER
LAPOS, MD, LINDA L LEHIGH
LAPP, MD, FREDERICK C LYCOMING
LARA, MD, HENRY R ERIE
LARACH, MD, DAVID R DAUPHIN
LAREAU, MD, DANIEL G WARREN
LAREAU, MD, LAWRENCE G WARREN
LARGE, MD, FRED D WASHINGTON
LARGE, MD, HIRAM S NORTHAMPTON
LARGENT, MD, JILL A MONTOUR
LARGOZA, MD, NACIANCENO T PHILADELPHIA
LARICCIA, MD, PATRICK J PHILADELPHIA
LARKIN, MD, FRANCIS L FAYETTE
LARKIN, MD, WILLIAM A FAYETTE
LARKIN JR, MD, MICHAEL J LAWRENCE
LARKIN JR, MD, VINCENT D LACKAWANNA
LARKIN JR, MD, WALTER J LACKAWANNA
LARKINS, MD, MARK V ALLEGHENY
LAROCHE, MD, ROGER R MCKEAN
LAROCHELLE, MD, ANNE G CRAWFORD
LAROCHELLE JR, MD, GERALD E CRAWFORD
LAROSSA, MD, DONATO D PHILADELPHIA
LARRAIN, MD, RICARDO J DAUPHIN
LARRIUZ, BERNICE M STUDENT
LARSON, MD, CHRISTOPHER E ALLEGHENY
LARSON, MD, ELEANOR TIOGA
LARSON, JEREMY T STUDENT
LARSON, MD, THOMAS J ALLEGHENY
LARSON JR, MD, THEODORE S LYCOMING
LASALVIA, MD, LUCY A PHILADELPHIA
LASCH, HUGH M STUDENT
LASEK, MD, COLETTE R MONTOUR
LASEK, MD, ROBERT W MONTOUR
LASHER, MD, J DONALD ERIE
LASHER, MD, ROBERT L ERIE
LASK, MD, GARY P PHILADELPHIA
LASKAS, CLAIRE A STUDENT
LASKAS, MD, JOHN J DELAWARE
LASKAS JR, MD, JOHN J DELAWARE
LASKY, MD, HENRY P MERCER
LATMAN, MD, STEPHEN F BERKS
LATOFF, MD, THOMAS J CHESTER
LATSHAW, MD, ROBERT F LANCASTER
LATTARI, VINCENT A STUDENT
LATTIMER, MD, GARY L LYCOMING
LATTIN, MD, GARY M BERKS
LATUSKA, MD, RICHARD F ALLEGHENY
LATZKO, MD, PAUL J LUZERNE
LAU, HAR C STUDENT
LAUANDOS, MD, IBRAHIM E BUCKS
LAUB, MD, CURTIS H CRAWFORD
LAUBACH, MD, GEORGE S NORTHAMPTON
LAUBACH JR, MD, CHARLES A MONTOUR
LAUCIUS, MD, J FREDERICK PHILADELPHIA
LAUCKS, MD, STEPHEN O YORK
LAUCKS II, MD, SAMUEL S YORK
LAUCKS JR, MD, STANLEY P YORK
LAUDENSLAGER, MD, ELMER C BUCKS
LAUFE, MD, MARC D ALLEGHENY
LAUFER, MD, ELIZABETH U PHILADELPHIA
LAUKAITIS, MD, RONALD B LANCASTER
LAUREANO, MD, REYNALDO E BUTLER
LAURO, MD, GREGORY R WESTMORELAND
LAURY, MD, WILLIAM L PHILADELPHIA
LAUTER, MD, O SCOTT LANCASTER
LAUTZ, MD, VIRGINIA H PHILADELPHIA
LAUZONIS, MD, PETER W LUZERNE
LAVAN, MD, DONALD W PHILADELPHIA
LAVANIER, MD, JEFFREY A SOMERSET
LAVERAN, RUDOLF L STUDENT
LAVERAN STIEBER, MD, RUDOLF F PHILADELPHIA
LAVERDE, MD, PHILIP S VENANGO
LAVIN-LESKA, MD, LINDA S BUCKS
LAVRICH, MD, JUDITH B PHILADELPHIA
LAW, MD, STUART C ALLEGHENY
LAWLESS, MD, GRANT D ALLEGHENY
LAWLOR, MD, MAUREEN ALLEGHENY
LAWLOR, MD, ROBERT J MONTGOMERY
LAWN, MD, BERYL B PHILADELPHIA
LAWRENCE, MD, GARY W LUZERNE
LAWRENCE, MD, JAMES B PHILADELPHIA
LAWRENCE, MD, JODY STUDENT
LAWRENCE, MD, JOHN W DELAWARE
LAWRENCE, MD, PHILIP H MONROE
LAWRENCE, MD, ROBINA R YORK
LAWRENCE, MD, THOMAS E DELAWARE
LAWSKY, MD, ALAN R ALLEGHENY
LAWSON, MD, LORI A PHILADELPHIA
LAWSON, MD, ROBIN A ALLEGHENY
LAY, SOPHIE A STUDENT
LAYCHOCK, MD, ANNA M SCHUYLKILL
LAYDEN, MD, PAUL W ERIE
LAYTON, MD, BRADLEY W WAYNE/PIKE
LAZAR, MD, JEFFREY C MERCER
LAZAR, JOEL S STUDENT
LAZARO MORAN, MD, MIGUELA D PHILADELPHIA
LAZARUS, MD, ARTHUR L MONTGOMERY
LAZARUS, DO, BEN G LANCASTER
LAZARUS, MD, GERALD S PHILADELPHIA
LAZOFF, MD, MARJORIE PHILADELPHIA
LAZORIK, MD, FRANCIS C DELAWARE
LAZZARO, MD, THEODORE A WESTMORELAND
LE, MD, DAHN VAN ALLEGHENY
LE, LARA STUDENT
LE, LONG V STUDENT
LEAHEY, MD, ALAN B LEHIGH
LEAHY, MD, JOANN M BUCKS
LEAL, MD, GUMERSINDO R SCHUYLKILL
LEAMAN, MD, IVAN B LANCASTER
LEAMAN, MD, PHYLLIS L LANCASTER
LEAMAN, MD, THOMAS L DAUPHIN
LEANO, ANN M STUDENT
LEAR, MD, WILLIAM L INDIANA
LEARNER, MD, NORMAN PHILADELPHIA
LEASE, MD, JOHN R LUZERNE
LEASER, MD, JOSEPH P DAUPHIN
LEASURE, MD, NICK C BERKS
LEATHERS, MD, DONALD J LYCOMING
LEATHERWOOD II, MD, DONALD F MONTGOMERY
LEAVENS, MD, HUGH M DAUPHIN
LEAVITT, MD, HERBERT M NORTHAMPTON
LEAVITT, DO, RICHARD JAY PHILADELPHIA
LEBEAU, MD, JACK MONTGOMERY
LEBER, MD, DAVID C DAUPHIN
LEBER, GEOFFREY E STUDENT
LEBER, MD, PAUL E LYCOMING
LEBERMAN, MD, PAUL R PHILADELPHIA
LEBISCHAK, MD, H CAROL LANCASTER
LEBON, FENTON G STUDENT
LEBOUITZ, MD, STANTON S YORK
LEBOVITZ, BRIAN L STUDENT
LEBOVITZ, MD, CHARLES N ALLEGHENY
LEBOVITZ, MD, JEROME J ALLEGHENY
LEBOWITZ, ARTHUR L STUDENT
LECAVALIER, MD, LARRY A BUCKS
LECHMANICK, MD, EUGENE A ALLEGHENY
LECHTZIN, NOAH STUDENT
LECKS, MD, LEONARD E PHILADELPHIA
LEDDY, MD, CHERYL PHILADELPHIA
LEDER, MD, DAVID S PHILADELPHIA
LEDESMA, MD, ELIHU J PHILADELPHIA
LEDIS, MD, SEYMOUR BUCKS
LEE, MD, AUNG P ERIE
LEE, MD, BERNARD L PHILADELPHIA
LEE, BRIAN K STUDENT
LEE, MD, CHANCHI BUCKS
LEE, MD, CHARLES Y DELAWARE
LEE, MD, CHONG S NORTHAMPTON
LEE, CHRISTOPHER S STUDENT
LEE, MD, CHUNG H CARBON
LEE, MD, DANIEL CHESTER
LEE, DANIEL D STUDENT
LEE, MD, DANIEL J PHILADELPHIA
LEE, MD, DAVID R FRANKLIN
LEE, MD, EDWARD Y LACKAWANNA
LEE, FELIX H STUDENT
LEE, MD, FERROL J BRADFORD
LEE, MD, FOO T ALLEGHENY
LEE, GUY A STUDENT
LEE, MD, H C NORTHAMPTON
LEE, HELEN STUDENT
LEE, MD, HENRY F PHILADELPHIA
LEE, MD, HOWARD J BUCKS
LEE, HYUN-JOO STUDENT
LEE, MD, HYUNAH PHILADELPHIA
LEE, MD, IN W ERIE
LEE, JAE H STUDENT
LEE, JAMES STUDENT
LEE, MD, JANGWOO SCHUYLKILL
LEE, MD, JEEN H NORTHAMPTON
LEE, MD, JOHN KEUN-SANG ALLEGHENY

LEE, MD, JONG Y	WESTMORELAND
LEE, MD, JUNG S	BERKS
LEE, MD, JUNG-PIL	BERKS
LEE, MD, KANG S	BLAIR
LEE, MD, KENNETH K	HUNTINGDON
LEE, MD, KI S	LUZERNE
LEE, MD, KUK S	FAYETTE
LEE, MD, KWAN I	ALLEGHENY
LEE, MD, KWANG W	PHILADELPHIA
LEE, MD, KYUNG C	LACKAWANNA
LEE, LAWRENCE H	STUDENT
LEE, MD, MARTIN L	MONTOUR
LEE, MD, MICHAEL W	ALLEGHENY
LEE, MD, OOK J	ALLEGHENY
LEE, MD, ROBERT E	ALLEGHENY
LEE, MD, ROTAN	PHILADELPHIA
LEE, MD, SAMUEL	BRADFORD
LEE, MD, SANG E	ALLEGHENY
LEE, MD, SANG T	NORTHAMPTON
LEE, DO, SARAH C	NORTHAMPTON
LEE, MD, SEUNG C	CRAWFORD
LEE, MD, SOOJI	ALLEGHENY
LEE, MD, STEPHEN E	ALLEGHENY
LEE, STEVEN J	STUDENT
LEE, MD, WILLIAM M	MONTGOMERY
LEE, MD, WINFRED J	ALLEGHENY
LEE, MD, WON Y	SCHUYLKILL
LEE, YI-CHUN	STUDENT
LEE, MD, YING P	FAYETTE
LEE, MD, YOUNG W	WAYNE/PIKE
LEE JR, MD, CHARLES T	PHILADELPHIA
LEE JR, MD, JAMES H	PHILADELPHIA
LEECH JR, MD, JOHN E	MONTOUR
LEEGARD, MD, ROBERT L	PHILADELPHIA
LEEHAN, MD, SEAN W	MERCER
LEEN, MD, RAYMOND L	ALLEGHENY
LEERS, MD, STEVEN A	ALLEGHENY
LEET, MD, THOMAS E	LEHIGH
LEFEVER, MD, ROBERT S	ADAMS
LEFF, MD, BERNARD	ALLEGHENY
LEFF, DO, DAVID A	NORTHAMPTON
LEFF, MD, LOUIS E	ALLEGHENY
LEFKOE, MD, ROY T	PHILADELPHIA
LEFTON, MD, HARVEY B	PHILADELPHIA
LEGENDRE, MD, GERALD M	MONTGOMERY
LEGERE, DO, JOHN B	LANCASTER
LEHMAN, MD, CLINTON J	LUZERNE
LEHMAN, DO, GREGORY M	DELAWARE
LEHMAN, MD, JOHN W	BEAVER
LEHMAN, MD, JULIA F	CAMBRIA
LEHMAN, MD, MATTHEW H	VENANGO
LEHMAN, MD, RALPH A	DAUPHIN
LEHMAN, MD, RUBY V	DAUPHIN
LEHMAN JR, NORMAN L	STUDENT
LEHMANN, MD, DAVID C	PHILADELPHIA
LEHRER, MD, LEWIS	PHILADELPHIA
LEHRER, MD, RICHARD A	PHILADELPHIA
LEHRICH, MD, HENRY E	LEHIGH
LEHRMAN, MD, BRUCE J	PHILADELPHIA
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LEIB JR, MD, RICHARD C	CAMBRIA
LEIBENSPERGER, MD, STEPHEN N	ALLEGHENY
LEIBMAN, MD, JOSEPH B	LACKAWANNA
LEIBOLD, MD, DEBRA M	MONTGOMERY
LEIBOWITZ, MD, ARTHUR N	DELAWARE
LEIBOWITZ, MD, LEONARD D	ALLEGHENY
LEIBY, MD, DAVID K	BUCKS
LEICHT, MD, JOHN P	YORK
LEICHT, MD, MICHAEL J	MONTOUR
LEIDNER, ELIZABETH A	STUDENT
LEIGH, MD, FLORA B	DELAWARE
LEIGH, MD, REWNG	WESTMORELAND
LEIGHT, MD, ROBIN L	BERKS
LEIGHTON, MD, CHARLES C	MONTGOMERY
LEIGHTON JR, MD, JOHN C	PHILADELPHIA
LEIGHTY, MD, RALPH G	SOMERSET
LEIMAN, MD, PAUL M	LACKAWANNA
LEINBERRY, MD, CHARLES F	BERKS
LEINWEBER, MD, BRUCE K	PHILADELPHIA
LEIPHART, MD, CLARENCE D	LANCASTER
LEIS, MD, DEAN J	DAUPHIN
LEISAWITZ, MD, ELLIOTT G	BERKS
LEISAWITZ, MD, PAUL A	BERKS
LEISE, MD, ELEANOR O	DELAWARE
LEISER, MD, JONATHON B	STUDENT
LEISTER, MD, HOWARD A	BUCKS
LEIT, MD, MICHAEL E	ALLEGHENY
LEITAO, MD, EDWARD A	ALLEGHENY
LEITEL, MD, HAROLD L	JEFFERSON
LEKACH, MD, JACUB	LACKAWANNA
LEKAWA, MD, THADDEUS	YORK
LELE, MD, PRAMOD S	DELAWARE
LEMAN, MD, WILLIAM W	DELAWARE
LEMASTERS, DO, THOMAS R	SCHUYLKILL
LEMASTERS, DO, WILLIAM C	NORTHMBRLAND
LEMBERG, MD, JEFFREY D	ALLEGHENY
LEMENTOWSKI, MD, MICHAL	FAYETTE
LEMERT, MD, MICHAEL R	CHESTER
LEMIS, MD, PETER M	ALLEGHENY
LEMLEK, DO, JOSEPH E	PHILADELPHIA
LEMOLE, MD, GERALD M	PHILADELPHIA
LEMPERT, MD, STEVEN L	ALLEGHENY
LENCHNER, MD, GREGORY S	PHILADELPHIA
LENGEL, MD, GARY P	BERKS
LENHARD, MD, SHARON M	PHILADELPHIA
LENKEY, MD, JOSEPH L	ALLEGHENY
LENNERT, MD, JOSEPH B	NORTHAMPTON
LENOX, MD, CORA C	ALLEGHENY
LENOX, MD, JOHN E	ALLEGHENY
LENOX, MD, ROBERT J	BRADFORD
LENTINI, MD, J CHARLES	LUZERNE
LENTO, PAUL H	STUDENT
LENTON, MD, HERBERT P	CUMBERLAND
LENTZ, MD, CONRAD L	NORTHAMPTON
LENTZ, MD, KENNETH H	ALLEGHENY
LENTZ, MD, MARK R	INDIANA
LENTZ, MD, ROBERT E	LEHIGH
LENYO, MD, GEORGE E	SCHUYLKILL
LEO, MD, LOUIS R	PHILADELPHIA
LEON, STUART M	STUDENT
LEONARD, DO, M DENICE	ALLEGHENY
LEONARD II, EDWARD E	STUDENT
LEONARD III, MD, DANIEL J	CAMBRIA
LEONARD JR, MD, EDWARD C	PHILADELPHIA
LEONE, MD, GUY R	WESTMORELAND
LEONE, LISA D	STUDENT
LEONG, MIMI	STUDENT
LEONG, PERRY L	STUDENT
LEONI, MD, JOSEPH	BERKS
LEONIDA, MD, ELFREN L	WESTMORELAND
LEOPOLD, DO, NORMAN A	DELAWARE
LEOPOLD, MD, ROBERT L	PHILADELPHIA
LEOPOLD, MD, RONALD S	PHILADELPHIA
LEOPOLD JR, MD, A REID	MIFFLIN/JUNI
LEPAR, MD, EDWIN	PHILADELPHIA
LEPIANE, MD, RICHARD M	BEAVER
LEPONE, MD, KENNETH	LEBANON
LEPORE, MARK S	STUDENT
LERBERG, MD, DAVID B	ALLEGHENY
LERMAN, MD, JOEL M	MONTGOMERY
LERMAN, MD, MICHAEL G	YORK
LERNER, MD, ARTHUR M	PHILADELPHIA
LERNER, MD, HARVEY J	PHILADELPHIA
LERNER, MD, SAMUEL M	LEHIGH
LERNER, SUSAN M	STUDENT
LEROY, MD, N BLAIR	MONTGOMERY
LERTZMAN, BETH H	STUDENT
LESACA, MD, TIMOTHY G	FAYETTE
LESCANIC, MD, MICHAEL L	CENTRE
LESCHEK, LISA M	STUDENT
LESCHEK, DO, RICHARD T	DELAWARE
LESH, MARK L	STUDENT
LESHNER, DO, RICHARD T	PHILADELPHIA
LESHOCK, MD, LEON E	CARBON
LESKO, MD, JULIANNE J	DAUPHIN
LESLIE, MD, DAVID C	WASHINGTON
LESLIE, MARTHA I	STUDENT
LESLIE, MD, PAUL A	LANCASTER
LESLIE JR, MD, M RUSSELL	ALLEGHENY
LESNIAK, MD, JOHN P	LACKAWANNA
LESNOCK, MD, ROBERT G	WASHINGTON
LESSE, MD, S MICHAEL	NORTHAMPTON
LESSER, MD, RAYMOND W	PHILADELPHIA
LESSIG, MD, HARRY J	PHILADELPHIA
LESTER, MD, MARK C	LEHIGH
LETO, MD, FRANCESCO	PHILADELPHIA
LETOCHA, MD, CHARLES E	YORK
LETWIN, MD, LEE B	MONTGOMERY
LEUKHARDT, MD, DAVID B	ALLEGHENY
LEUNISSEN, MD, REINHARD L A	DELAWARE
LEUTE, MD, MILLARD S	DELAWARE
LEVANDOSKI, MD, DIANE C	LUZERNE
LEVANDOSKI JR, MD, GERALD J	LUZERNE
LEVARI, MD, ISAAC	ALLEGHENY
LEVENE, MD, JACK M	SUSQUEHANNA
LEVENSON, MD, DAVID J	ALLEGHENY
LEVENSON, MD, MORTON W	LANCASTER
LEVENTHAL, MD, LAWRENCE J	PHILADELPHIA
LEVENTHAL, MD, LINDA C	BUCKS
LEVEY, ERIC B	STUDENT
LEVICK, MD, MARVIN H	ALLEGHENY
LEVICK, MD, STANLEY N	PHILADELPHIA
LEVICK, MD, STEPHEN E	PHILADELPHIA
LEVIEN, MD, DAVID H	PHILADELPHIA
LEVIN, MD, ALEX V	PHILADELPHIA
LEVIN, MD, ANDREW J	PHILADELPHIA
LEVIN, MD, BARRY L	PHILADELPHIA
LEVIN, MD, BRADLEY H	YORK
LEVIN, MD, DANIEL M	DAUPHIN
LEVIN, MD, ERIC J	DELAWARE
LEVIN, MD, GARY J	CHESTER
LEVIN, MD, GENE D	BUCKS
LEVIN, MD, HOWARD A	MONTGOMERY
LEVIN, MD, I HOWARD	PHILADELPHIA
LEVIN, JENNIFER A	STUDENT
LEVIN, MD, KENNETH	NORTHAMPTON
LEVIN, MD, LARRY L	ALLEGHENY
LEVIN, MD, MARC W	LEHIGH
LEVIN, MD, MATTHEW W	ALLEGHENY
LEVIN, MD, MICHAEL D	PHILADELPHIA
LEVIN, MD, MOISEY	BUCKS
LEVIN, MD, MORRIS	BUCKS
LEVIN, MD, NORMAN P	PHILADELPHIA
LEVIN, MD, RICHARD L	BUCKS
LEVIN, MD, RICHARD M	LANCASTER
LEVIN, MD, ROBERT M	BLAIR
LEVIN, MD, RONALD M	PHILADELPHIA
LEVIN, STEVEN I	STUDENT
LEVIN, MD, STEVEN P	MONTGOMERY
LEVINE, MD, ALAN P	BERKS
LEVINE, MD, ARNOLD H	PHILADELPHIA
LEVINE, MD, ARTHUR L	LEHIGH
LEVINE, MD, BRETT A	PHILADELPHIA
LEVINE, MD, BRUCE D	ALLEGHENY
LEVINE, MD, CHARLES B	YORK
LEVINE, MD, CHARLES R	LEHIGH
LEVINE, MD, JACOB	WESTMORELAND
LEVINE, DO, JEFFREY N	LANCASTER
LEVINE, MD, JOEL I	ADAMS
LEVINE, MD, MACY I	ALLEGHENY
LEVINE, MD, MARK A	MONTOUR
LEVINE, MD, MARK J	ERIE
LEVINE, MD, MICHAEL	ALLEGHENY
LEVINE, MD, MICHAEL G	PHILADELPHIA
LEVINE, MD, PHILLIP R	ALLEGHENY
LEVINE, MD, RICHARD B	PHILADELPHIA
LEVINE, MD, SHELDON R	ALLEGHENY
LEVINE, MD, STUART E	PHILADELPHIA
LEVINSKY, MD, WALTER J	PHILADELPHIA
LEVINSON, MD, BRADLEY A	ALLEGHENY
LEVINSON, MD, JULIAN P	ALLEGHENY
LEVINSON, MD, MARK E	STUDENT
LEVINSON, MD, NAT E	LACKAWANNA
LEVINSON, MD, PETER G	ERIE
LEVINSON, MD, SANDER J	LACKAWANNA
LEVINSON, MD, STUART L	PHILADELPHIA
LEVINSON, MD, WILLIAM D	WESTMORELAND
LEVIS, MD, MICHAEL P	ALLEGHENY
LEVIT, MD, EDITHE J	PHILADELPHIA
LEVIT, MD, LAWRENCE S	PHILADELPHIA
LEVIT, MD, SAMUEL M	PHILADELPHIA
LEVITT, MD, JERRY D	PHILADELPHIA
LEVITT, MD, LAWRENCE P	LEHIGH
LEVITZ, CRAIG L	STUDENT
LEVY, MD, DAVID J	ERIE
LEVY, MD, EDWIN J	DELAWARE
LEVY, MD, JON A	ALLEGHENY
LEVY, MD, LESLIE J	ALLEGHENY
LEVY, MD, MARGARET	MONTGOMERY
LEVY, MD, MARK A	ALLEGHENY
LEVY, MD, MARSHALL S	ALLEGHENY
LEVY, MD, MICHAEL H	PHILADELPHIA
LEVY, MD, PAUL F	BERKS
LEVY, MD, REINHARDT D	ALLEGHENY
LEVY, MD, ROBERT W	ALLEGHENY
LEVY, MD, SCOTT S	BUCKS
LEVY, MD, STEVEN A	ERIE
LEVY, MD, WILLIAM K	MONTGOMERY
LEW, MD, CHUNG M	BEAVER
LEWANDOWSKI, MD, ANN E	FRANKLIN
LEWBART, MD, MARVIN L	DELAWARE
LEWIN, MD, JULIAN R	ALLEGHENY
LEWIN, MD, STANLEY B	DAUPHIN
LEWINE, MD, YALE S	CAMBRIA
LEWIS, MD, ALAN E	PHILADELPHIA
LEWIS, MD, ALLAN A	PHILADELPHIA
LEWIS, MD, DANIEL W	PHILADELPHIA
LEWIS, MD, EARL T	CHESTER
LEWIS, MD, ELAINE R	BERKS
LEWIS, MD, GARY W	WESTMORELAND
LEWIS, GENA L	STUDENT
LEWIS, MD, GREGORY L	CUMBERLAND
LEWIS, MD, HENRY C	WESTMORELAND
LEWIS, MD, IVOR	NORTHMBRLAND
LEWIS, MD, JAMES W	PHILADELPHIA
LEWIS, MD, JOFFRE P	SCHUYLKILL
LEWIS, MD, JOSEPH G	BERKS
LEWIS, DO, KATHLEEN C	LYCOMING
LEWIS, MD, KATHRYN A	BLAIR
LEWIS, MD, KENNETH E	PHILADELPHIA
LEWIS, MD, L CLIFFORD	CHESTER
LEWIS, MD, MAURICE J	DAUPHIN
LEWIS, NANCY L	STUDENT
LEWIS, MD, PAUL L	PHILADELPHIA
LEWIS, MD, RACHEL E	MONTGOMERY
LEWIS, MD, REBECCA E	MONTGOMERY
LEWIS, MD, RICHARD P	ALLEGHENY
LEWIS, MD, ROBERT E	ALLEGHENY
LEWIS, MD, STEPHEN F	MONTGOMERY
LEWIS, MD, STUART H	DELAWARE
LEWIS, WALTER E	STUDENT
LEWIS, MD, WILLIAM J	DELAWARE
LEWIS JR, MD, GEORGE C	PHILADELPHIA
LEWIS JR, MD, HOWARD T	ALLEGHENY
LEWIS JR, MD, THOMAS J	ALLEGHENY
LEXA, MD, FRANK J	PHILADELPHIA
LEY, MD, JAMES S	PHILADELPHIA
LEYZIN, MD, FELIX	PHILADELPHIA
LEYZIN, MD, MARA S	PHILADELPHIA
LEZEK, MD, VINCENT J	ALLEGHENY
LI, SHERYL G	STUDENT
LIACHOWITZ, MD, CLAIRE H	PHILADELPHIA
LIANG, MD, DAVID Y	ALLEGHENY
LIANG, MD, GWENDOLYN J	MONTGOMERY
LIANG, MD, MARC D	ALLEGHENY
LIANG, MD, MARIA	ALLEGHENY
LIANG, MD, PING TCHANG	ALLEGHENY
LIAW, MD, MING T	PHILADELPHIA
LIAW, MD, WEN HAW	PHILADELPHIA
LIBERACE, MD, ETTORE V	CHESTER
LIBERI, MD, ALFRED A	DELAWARE
LIBERTA, MD, THOMAS R	NORTHAMPTON
LICHTENBERG, MD, RICHARD A	DELAWARE
LICHTENSTEIN, MD, ISRAEL	PHILADELPHIA
LICHTENSTEIN, SETH H	STUDENT
LICHTENSTEIN, MD, STEPHEN B	PHILADELPHIA
LICHTENSTEIN, DO, STEVEN	PHILADELPHIA
LICHTER, MD, JAMES G	ALLEGHENY
LICHTMAN, MD, JOSEPH M	PHILADELPHIA
LIDDELL, MD, ALBERT G	LYCOMING
LIDSTON, MD, BRUCE M	HUNTINGDON
LIEB, MD, JOHN G	YORK
LIEBENBERG, MD, ROBERT E	PHILADELPHIA
LIEBENTRITT, MD, FRANK J	CRAWFORD
LIEBER, MD, CLAUDE P	PHILADELPHIA
LIEBER, MD, PAUL S	CENTRE
LIEBERMAN, MD, BRUCE L	BUCKS
LIEBERMAN, MD, CRAIG	PHILADELPHIA
LIEBERMAN, MD, DANIEL	PHILADELPHIA
LIEBERMAN, MD, DONALD C	LUZERNE
LIEBERMAN, MD, DONALD H	PHILADELPHIA
LIEBERMAN, MD, FRANCIS A	LEHIGH
LIEBERMAN, MD, GEORGE E	PHILADELPHIA
LIEBERMAN, MD, RICHARD M	LEHIGH
LIEBERMAN, DO, RONALD M	PHILADELPHIA
LIEBERMAN JR, MD, JOSEPH A	LEHIGH
LIEBERT, MD, PAUL L	PHILADELPHIA
LIEBLER, MD, GEORGE A	ALLEGHENY
LIEBMAN, MD, EMIL P	PHILADELPHIA
LIEBMAN, MD, IRVIN M	BUCKS
LIEDERBACH, MD, STEPHEN J	ALLEGHENY
LIEF, MD, HAROLD I	PHILADELPHIA
LIEFELD, MD, PAUL A	ALLEGHENY
LIFE, MD, JEFFRY S	WYOMING
LIGGETT, MD, JOHN S	ALLEGHENY
LIGGETT, MD, JOSEPH G	ALLEGHENY
LIGHT, MD, HARRY G	NORTHAMPTON
LIGHT, MD, JOHN H	CENTRE
LIGHT, MD, JOHN J B	LEBANON
LIGHT, MD, KAREN L	PHILADELPHIA
LIGHT, MD, WILMA C	WESTMORELAND
LIGHTMAN, MD, DAVID A	LYCOMING
LIGHTS, MD, VERNEDA M	PHILADELPHIA
LIGNELLI, MD, GREGORY J	BERKS
LILIENTHAL, MD, DAVID S	ALLEGHENY
LILIK, MD, KENNETH W	LACKAWANNA
LILJA, MD, JAMES F	STUDENT
LILJESTRAND, MD, JANET D	BEAVER
LILLEY, MD, GEORGE W	DELAWARE
LILLI, MD, ELMO J	MONROE
LILLMARS, DO, STEVEN A	MONTOUR
LILLY, DO, TIMOTHY J	MERCER
LIM, ALEXANDER J	STUDENT
LIM, MD, CHANG-SEIN	WAYNE/PIKE
LIM, MD, DAWSON	ALLEGHENY
LIM, MD, ELIZABETH G	INDIANA
LIM, MD, FELIXBERTO D	ALLEGHENY
LIM, MD, HENG-FENG	DAUPHIN
LIM, LINATH	STUDENT
LIM, MD, LOURDES T	MERCER
LIM, MD, REBECCA B	BRADFORD
LIM, DO, SCOTT J M	ERIE
LIM, MD, YOUNG K	WESTMORELAND
LIMA, MD, CLAUDIO A B	ALLEGHENY
LIMBERAKIS, MD, ANTHONY J	PHILADELPHIA
LIMBERGER, MD, WILLIAM A	CHESTER
LIMBERT, MD, LAWRENCE	MONTGOMERY
LIMKAKENG, MD, ALEXANDER D	MERCER
LIMOGES, MD, RICHARD F	PHILADELPHIA
LIMPERT, MD, GEORGE H	WYOMING
LIN, MD, CHING H	SCHUYLKILL
LIN, HENRY C	STUDENT
LIN, MD, HONG-DER	ALLEGHENY
LIN, MD, LUKE	ALLEGHENY
LIN, MD, MING-SHEK	ALLEGHENY
LIN, MD, PAUL M	PHILADELPHIA
LIN, MD, PAUL S	UNION
LIN, MD, PU CHING	ELK/CAMERON
LIN, RICHARD J	STUDENT
LIN, MD, RONG-CHUNG	ALLEGHENY
LIN, MD, SHIOW-BIH	ALLEGHENY
LINCOFF, MD, WILLIAM	DELAWARE
LIND, THOMAS E	STUDENT
LINDBERG, MD, NICHOLAS O	BUCKS
LINDBLAD, MD, JOHN H	ALLEGHENY
LINDENBAUM, MD, GARY A	DELAWARE
LINDENBAUM, MD, JORGE	ALLEGHENY
LINDENFELD, MD, ARTHUR	LEHIGH
LINDENTHAL, MD, JOHN P	ALLEGHENY
LINDER, MD, LISA J	DELAWARE
LINDER, MD, PAUL G	ALLEGHENY
LINDER, MD, STEPHANIE L	YORK
LINDNER, MD, MARIE A	CHESTER
LINDQUIST, MD, JOHN N	PHILADELPHIA
LINDSAY, MD, DAVID A	LYCOMING
LINE, MD, DENNIS E	CUMBERLAND
LING, MD, CARL H	BUTLER
LING, MD, CHARLES C	SCHUYLKILL
LING, MD, HENRY T	MONTGOMERY
LINGANNA, MD, BHATTARAHALLY Y	LAWRENCE
LINGARAJU, MD, NAGARAJ	PHILADELPHIA
LINGENFELTER, MD, KYLE A	BRADFORD
LINGLE, MD, DAVID M	PHILADELPHIA
LINHART, MD, RANDOLPH W	ALLEGHENY
LININGER, MD, JOHN R	MONTGOMERY
LININGER, MICHAEL D	STUDENT
LINK, MD, DANIEL E	ALLEGHENY
LINN, DO, ROBERT	PHILADELPHIA
LINN, MD, SHELDON H	BUCKS
LINN JR, MD, JAY G	ALLEGHENY
LINNEMANN, MD, ROGER E	PHILADELPHIA
LINS, MD, JEFFREY A	BEAVER
LINSKEY, MD, MARK E	ALLEGHENY
LINTGEN, MD, ARTHUR B	MONTGOMERY
LINTZMEYER, MD, EMIL A	DELAWARE
LINVILLE, MD, DOUGLAS A	ALLEGHENY
LIPANA, MD, OSCAR N	ALLEGHENY
LIPAPIS, MD, CHRISTY N	ALLEGHENY
LIPES, MD, JAN K	BUCKS
LIPKIN, MD, DAVID E	MONTGOMERY
LIPKIN, DO, HERBERT J	PHILADELPHIA
LIPMAN, MD, BERNARD L	PHILADELPHIA
LIPMAN, MD, RODNEY C	ALLEGHENY
LIPMAN, MD, SIDNEY P	ERIE
LIPNACK, DO, ERIC M	MONTGOMERY
LIPPA, MD, ERIK A	PHILADELPHIA
LIPPA, MD, LINDA S M	PHILADELPHIA
LIPPE, MD, RONALD W	DAUPHIN
LIPPERT, MD, LOUIS C	JEFFERSON
LIPPMAN, CALEB R	STUDENT
LIPPO, MD, FRANK L	PHILADELPHIA
LIPSCHUTZ, MD, ARTHUR	PHILADELPHIA
LIPSCHUTZ, MD, LOUIS B	PHILADELPHIA
LIPSCHUTZ, MD, STEVEN M	PHILADELPHIA
LIPSENTHAL, MD, LEE	PHILADELPHIA

LIPSHUTZ, MD, HAROLD	PHILADELPHIA
LIPSHUTZ, MD, HUGH	MONTGOMERY
LIPSHUTZ, MD, WILLIAM H	PHILADELPHIA
LIPSITZ, MD, H DAVID	ALLEGHENY
LIPSIUS, MD, EDWARD I	PHILADELPHIA
LIPSON, MD, CHERYL S	CARBON
LIPSON, MD, JOHN D	INDIANA
LIPSON, MD, M BARRY	BUCKS
LIPSON, MD, STEPHEN D	LYCOMING
LIPTON, MD, ERIC C	LANCASTER
LIPTON, MD, STEVEN E	MONTGOMERY
LIS, MD, EDWARD T	YORK
LISAN, MD, PHILIP	PHILADELPHIA
LISBERGER, MD, MARK D	DELAWARE
LISI, MD, LOUISE M	PHILADELPHIA
LISKA, MD, JOHN R	WESTMORELAND
LISKER, MD, SHELDON A	PHILADELPHIA
LISNYCZYJ, MD, NICHOLAS	LACKAWANNA
LISOWITZ, MD, GERALD M	WESTMORELAND
LISS, MD, ARTHUR	LUZERNE
LISS, MD, GILBERT A	CHESTER
LISS, MD, JONATHAN	YORK
LISS, MD, ROBERT G	ALLEGHENY
LISS, MD, ROBERT P	CHESTER
LISTA, MD, WILLIAM A	PHILADELPHIA
LISTMAN, DAVID A	STUDENT
LISTWA, DO, HOWARD M	LEHIGH
LISZKA, DO, ANNE-MARIE	BLAIR
LITCHMAN, MD, JOSEPH F	LUZERNE
LITCHMAN, MD, MAUREEN R	LUZERNE
LITMAN, DO, RANDY G	MONTGOMERY
LITOVSKY, MD, DANIEL A	BUCKS
LITRENTA, MD, DAVID E	YORK
LITT, MD, LAWRENCE M	MONTGOMERY
LITTLE, MD, G ROBERT	DAUPHIN
LITTLE, MD, ROBERT G	DAUPHIN
LITTLE, MD, THOMAS	NORTHAMPTON
LITTMAN, MD, JEFFREY JAY	PHILADELPHIA
LITTON, MD, JASON J	DAUPHIN
LITTON, MD, LINDA T	DAUPHIN
LITVIN, MD, HENRY	MONTGOMERY
LITWIN, MD, JEFFREY S	MONTGOMERY
LIU, CHIENYING	STUDENT
LIU, MD, JOHN SHIE-PING	ALLEGHENY
LIU, MICHAEL	STUDENT
LIU, MD, PHILIP G	WAYNE/PIKE
LIU, MD, ROSITA O	WAYNE/PIKE
LIU, SAM S	STUDENT
LIU, MD, WINSTON T	PHILADELPHIA
LIVECCHI, MD, JOHN T	LACKAWANNA
LIVENGOOD, MD, MARGARET A	LUZERNE
LIVOLSI, MD, PHILIP D	PHILADELPHIA
LIVORNESE, MD, DOUGLAS S	PHILADELPHIA
LIVORNESE JR, MD, LAWRENCE L	PHILADELPHIA
LIZANO, MD, VIOLETA M	LACKAWANNA
LLEWELLYN, MD, AMY L	PHILADELPHIA
LLINAS, MD, ALFREDO J	BRADFORD
LLOYD, MD, BENJAMIN J	BERKS
LLOYD, MD, EDGAR C	BERKS
LLOYD, MD, GERALD R	ERIE
LLOYD, MD, JON C	ALLEGHENY
LO, MD, SHIH C	ALLEGHENY
LOBAS, MD, DAVID M	ALLEGHENY
LOBEL, MD, JEFFREY S	MONTOUR
LOBES JR, MD, LOUIS A	ALLEGHENY
LOBITZ, MD, STANLEY A	LUZERNE
LOBL, MD, LAWRENCE T	ALLEGHENY
LOCKE, MD, DARRON B	BLAIR
LOCKE, MD, DAVID L	ALLEGHENY
LOCKE, MD, HARRY R	MONTGOMERY
LOCKEY III, MD, STEPHEN D	LANCASTER
LODER, DO, DONALD I	BERKS
LODISE, MD, RAYMOND J	PHILADELPHIA
LOEB, MD, ROBERT L	ERIE
LOEB, MD, ROLAND A	LANCASTER
LOEFFLER JR, MD, JOHN G	CUMBERLAND
LOEPER, MD, DONALD J	BERKS
LOEV, MD, MARVIN	BUCKS
LOEW, MD, CLIFFORD G	PHILADELPHIA
LOEWENBERG, MD, LEOPOLD S	PHILADELPHIA
LOFARO, MD, SALVATORE A	DELAWARE
LOFFREDA-MANCINELLI, MD, CLAUDIO	BEAVER
LOFFREDO, MD, LINDA S	LUZERNE
LOFTUS, MD, JOSEPH A	LUZERNE
LOFTUS, MD, THOMAS A	PHILADELPHIA
LOFTUS, MD, THOMAS M	PHILADELPHIA
LOGAN, DAVID A	STUDENT
LOGAN, MD, KENNETH M	ALLEGHENY
LOGAN, MD, LEWIS P	LYCOMING
LOGAN, MD, MARTHA L	PHILADELPHIA
LOGAN, MD, THOMAS M	PHILADELPHIA
LOGUE, MD, JAMES G	PHILADELPHIA
LOGUE III, MD, JAMES G	BERKS
LOH, MD, CHARLES K	CUMBERLAND
LOHIER, MD, RAYMOND	PHILADELPHIA
LOHIN, DO, DAVID L	LACKAWANNA
LOK, MD, MAI PAI	SCHUYLKILL
LOKEY, MD, PATRICIA A	PHILADELPHIA
LOLLEY, MD, DAVID M	ALLEGHENY
LOMAGO, DEAN F	STUDENT
LOMAX JR, MD, WALTER P	PHILADELPHIA
LOMBARD, MD, MICHAEL F	LUZERNE
LOMBARD, MD, ROBERT M	LANCASTER
LOMBARD JR, MD, ROBERT M	DAUPHIN
LOMBOY, MD, NORMA T	LEHIGH
LONDINO JR, MD, ALDO V	ALLEGHENY
LONDON, MD, GLADYS Z	DELAWARE
LONDON, MD, PHILIP	PHILADELPHIA
LONDON, MD, W THOMAS	PHILADELPHIA
LONERGAN, MD, ROBERT P	DAUPHIN
LONG, MD, DAVID A	DAUPHIN
LONG, MD, DAVID F	CHESTER
LONG, MD, EDWIN T	ALLEGHENY
LONG, MD, J STEPHEN	YORK
LONG, MD, JOSEPH P	CUMBERLAND
LONG, MD, PAUL R	LUZERNE
LONG, MD, RICHARD A	WASHINGTON
LONG, MD, RICHARD W	ERIE
LONG, MD, ROBERT D	UNION
LONG, MD, RONALD A	HUNTINGDON
LONG, MD, THEODORE K	LEBANON
LONG JR, MD, HERBERT C	INDIANA
LONG JR, MD, WILLIAM C	CLINTON
LONGACRE, MD, JANE M	MONTGOMERY
LONGARINI, MD, AMILCAR E	SCHUYLKILL
LONGARINI, MD, RICARDO	SCHUYLKILL
LONGENBACH, MD, ERIC W	LYCOMING
LONGENECKER, MD, BENJAMIN E	BERKS
LONGENECKER, MD, ROGER N	BERKS
LONGENECKER, MD, STEPHEN C	BERKS
LONGENHAGEN, MD, JOHN B	LEHIGH
LONGNECKER, MD, DAVID E	PHILADELPHIA
LONGO, MD, SANTO	NORTHAMPTON
LONGO-MALLOY, DO, DEBORAH R	PHILADELPHIA
LONGWELL, MD, ROBERT H	LANCASTER
LONGWELL JR, MD, BENTON E	CAMBRIA
LONSDORF, MD, RICHARD G	PHILADELPHIA
LOOMIS, MD, MARIO G	CHESTER
LOOSE, DO, GEORGE T	LEBANON
LOOSE, MD, JEFFREY H	PHILADELPHIA
LOPATOFSKY, MD, DAVID J	LYCOMING
LOPEZ, MD, AISA G	PHILADELPHIA
LOPEZ, MD, FRANK W	DAUPHIN
LOPONTE, MD, MARIE A	PHILADELPHIA
LOPUSNIAK, MD, MIECZYSLAW S	DELAWARE
LORA, MD, JUAN A	DELAWARE
LORAH, MD, KEVIN N	MONTOUR
LORBER, MD, STANLEY H	PHILADELPHIA
LORD, MD, BRIAN	PHILADELPHIA
LORD, MD, KENNETH J	ERIE
LORD, MD, WILLIAM H	BERKS
LOREMAN, DO, LORIE	BUCKS
LORENTZ, MD, GERALD T	FRANKLIN
LORENZ, MD, HOWARD	PHILADELPHIA
LORENZ III, MD, STEPHEN A	ALLEGHENY
LORENZO, MD, FREDERICK V	ADAMS
LORRAINE, MD, RICHARD S	MONTGOMERY
LORRY, MD, RALPH W	PHILADELPHIA
LOS, BRIAN A	STUDENT
LOSKEN, MD, H WOLFGANG	ALLEGHENY
LOSS, DO, BETH A	YORK
LOTLIKAR, JEFFREY P	STUDENT
LOTTICK, MD, EDWARD A	LUZERNE
LOTZ, MD, ANDREW J	CHESTER
LOUGH, MD, FREDERICK C	BERKS
LOUGHEAD JR, MD, JOHN R	BERKS
LOUGHMAN, MD, LINDA	ALLEGHENY
LOUIS-CHARLES, MD, ROY	PHILADELPHIA
LOUTON, MD, ROBERT B	BLAIR
LOUX, MD, NORMAN L	BUCKS
LOVE, MD, CAROL A	PHILADELPHIA
LOVE, MD, MICHAEL B	PHILADELPHIA
LOVE, MD, WILLARD H	DAUPHIN
LOVECCHIO, MD, FRANCIS A	MONROE
LOVELL, MD, DONALD R	BLAIR
LOVERANES, MD, MARIANO D	ERIE
LOVETT, MD, GEORGE W	ALLEGHENY
LOVETT, MD, WILLIAM J	LEBANON
LOVETTE, MD, JOHN B	CAMBRIA
LOVRINIC, MD, DANIEL F	LUZERNE
LOVRINIC, MD, WILLIAM S	CHESTER
LOW, MD, DIONG O	PHILADELPHIA
LOW, MD, JOANNE E	PHILADELPHIA
LOWDER JR, MD, RALPH J	ALLEGHENY
LOWE, MD, CHERYL F	CHESTER
LOWE, MD, DAVID A	PHILADELPHIA
LOWE, MD, DIANE A	LUZERNE
LOWE, MD, STEPHEN J	PHILADELPHIA
LOWENGRUB, MD, KATHERINE M	ALLEGHENY
LOWENSTEIN, MD, ROBERT A	WASHINGTON
LOWER, MD, TERI A	ALLEGHENY
LOWERY, MD, WILLA D	ALLEGHENY
LOWES, MD, ROBERT J	PHILADELPHIA
LOWMAN, MD, GERALD F	NORTHAMPTON
LOWRY, MD, DON A	CAMBRIA
LOWRY, MD, DONALD J	DAUPHIN
LOWRY, MD, LOUIS D	PHILADELPHIA
LOWY JR, MD, ALEXANDER D	ALLEGHENY
LOZANO, MD, RAMON G	ALLEGHENY
LU, MD, LUIS W	ELK/CAMERON
LU, MELVIN C	STUDENT
LU, MD, MILTON M	LANCASTER
LU, RAVY S	STUDENT
LUBAHN, MD, JOHN D	ERIE
LUBBE, MD, WILLEM J	LYCOMING
LUBIC, MD, LOWELL G	ALLEGHENY
LUBICK, MD, CAROLINE J	ALLEGHENY
LUBIN, DO, HOWARD S	DELAWARE
LUBIN, MD, JOSEPH D	PHILADELPHIA
LUBINSKI, STUART M	STUDENT
LUBIZKA, MD, ALEXANDRA	PHILADELPHIA
LUBOW, MD, HARRY	WESTMORELAND
LUCAS, MD, DONNA M	ALLEGHENY
LUCAS, MD, GLYNDA W	STUDENT
LUCAS, MD, JUDITH A	ALLEGHENY
LUCAS, MD, R DUBOIS	PHILADELPHIA
LUCAS, MD, RICHARD M	LANCASTER
LUCAS, TIMOTHY A	STUDENT
LUCAS-FEHM, MD, LYNN MICHELE	PHILADELPHIA
LUCENA, MD, AURORA L	DELAWARE
LUCENA, MD, ERNESTO E	DELAWARE
LUCEY III, MD, DENIS J	PHILADELPHIA
LUCHETTE, MD, ALBERT A	MERCER
LUCIER, MD, ALFRED C	DELAWARE
LUCINE JR, MD, ALBERT A	CHESTER
LUCKENBAUGH, MD, AMY S	YORK
LUDIVICO, MD, CHARLES L	NORTHAMPTON
LUDKIEWICZ, MD, WAYNE S	BEAVER
LUDMER, MD, MARIO	ALLEGHENY
LUDOLPH, MD, CAROL ANN	PHILADELPHIA
LUDWICK, MD, DAVID J	BUCKS
LUDWIG, MD, KARL D	ALLEGHENY
LUDWIG, MD, KARLA M	LEBANON
LUECKE, MD, GAIL A	BERKS
LUFT, MD, WILLIAM C	BRADFORD
LUGO, MD, FABIO H	PHILADELPHIA
LUGO, MD, STEVEN J	BLAIR
LUGUE, MD, CARMELA S	CLEARFIELD
LUGUE JR, MD, AMADO B	CLEARFIELD
LUI, MD, NELSON L	PHILADELPHIA
LUK, MD, STEPHEN S	DAUPHIN
LUKACS, MD, KORNEL	BLAIR
LUKAS, MD, MARYANN E	MONTGOMERY
LUKAS, MD, RAYMOND A	LYCOMING
LUKASZCZYK, MD, JOHN J	NORTHAMPTON
LUKASZCZYK, MD, THOMAS A	NORTHAMPTON
LUMISH, MD, ROBERT M	ALLEGHENY
LUN, MD, LAPMAN	PHILADELPHIA
LUNA, MD, FREDESVINDA	CLEARFIELD
LUNA, MD, ROBERTO S	CLEARFIELD
LUND, MD, PEERE C	CAMBRIA
LUND, MD, PETER S	ERIE
LUNDIE, MD, WILLIAM M	WESTMORELAND
LUNDY, MD, BARBARA S	MONTGOMERY
LUNDY, MD, EDWARD F	LANCASTER
LUNDY, MD, THEODORE	PHILADELPHIA
LUNING-PRAK, ELINE T	STUDENT
LUNSFORD, MD, L DADE	ALLEGHENY
LUO, MD, SOLOMON C	SCHUYLKILL
LUONGO JR, MD, ROMEO A	PHILADELPHIA
LUPARELLO, MD, FRANK J	ALLEGHENY
LUPARIELLO, MD, ANGELO D	ALLEGHENY
LUPAS, MD, JOHN A	MONTGOMERY
LUPINACCI, MD, MICHAEL F	DAUPHIN
LUPINETTI, MD, MICHAEL F	ALLEGHENY
LURIE, MD, ABRAHAM A	MONTGOMERY
LURIE, SHARI D	STUDENT
LUSCH, MD, CHARLES J	BERKS
LUSCOMBE, MD, HERBERT A	PHILADELPHIA
LUSCOMBE, MD, HERBERT J	BUCKS
LUSH, MD, DAVID T	PHILADELPHIA
LUSSER, MD, MARTHA A	LEHIGH
LUSTBADER, MD, MICHAEL L	BEAVER
LUSTIG, MD, KEITH A	ERIE
LUSZCZYNSKA, MD, KAZIA M	PHILADELPHIA
LUTHER, JOSEPH H	STUDENT
LUTHER, MD, ROBERT J	CAMBRIA
LUTHRA, MD, DAMYANTI	WESTMORELAND
LUTHRA, MD, MANMOHAN S	WESTMORELAND
LUTNESS, MD, MARK P	MONTOUR
LUTZ, MD, CHARLES K	BERKS
LUTZ, MD, RAYMOND J	LEHIGH
LUTZ, MD, RONALD A	LEHIGH
LUTZ, WENDY J	STUDENT
LUTZ JR, MD, ROLAND B	MONTGOMERY
LWIN, MD, TINT	ALLEGHENY
LYCHAK, MD, JOHN C	NORTHAMPTON
LYET, MD, J PAUL	LANCASTER
LYKENS, MD, HARRY D	CENTRE
LYNAM, MD, EDWARD P	ALLEGHENY
LYNCH, DO, CHRISTOPHER B	MONROE
LYNCH, MD, CHRISTOPHER G	LEHIGH
LYNCH, MD, FRANK C	LEBANON
LYNCH, MD, JAMES D	BERKS
LYNCH, MD, JAMES J	PHILADELPHIA
LYNCH, MD, THOMAS G	ALLEGHENY
LYNCH, DO, WILLIAM J	CLARION
LYND JR, MD, CLIFFORD W	YORK
LYNESS, MD, SAMUEL S	MONTGOMERY
LYNN, MD, CHARLES A	BUTLER
LYNN, MD, RICHARD E	WESTMORELAND
LYON-LOFTUS, MD, GREGORY T	FRANKLIN
LYONS, MD, CAROLANN W	ERIE
LYONS, MD, CHRISTINE W	CHESTER
LYONS, MD, CHRISTOPHER J	CHESTER
LYONS, MD, CLIFFORD H	BERKS
LYONS, MD, DANIEL C	BUCKS
LYONS, MD, GARY W	ERIE
LYONS, MD, JOHN C	ERIE
LYONS, MD, WILBERT A	BUCKS
LYTER, MD, DAVID W	ALLEGHENY
LYTLE, MD, LARRY H	CLINTON

M

MA, MD, JOSE M	LANCASTER
MAAS, MD, ANTHONY E	DAUPHIN
MAAS, MD, KURT D	LUZERNE
MABRY, MD, MICHAEL E	ALLEGHENY
MAC CART, MD, JOHN G	MONTGOMERY
MACAGY, MD, IAN D	BERKS
MACALUSO, MD, RUSSELL A	CUMBERLAND
MACARANAS, MD, RENATO R	CLEARFIELD
MACCHIAROLI, MD, JOSEPH A	ALLEGHENY
MACCHIAVELLI, ANTHONY J	STUDENT
MACDONALD, MD, DOUGLAS A	ALLEGHENY
MACDONALD, MD, GEORGE F	ALLEGHENY
MACDONALD, MD, JOHN S	PHILADELPHIA
MACDONALD, MD, ROBERT R	ALLEGHENY
MACDOUGALL, MD, HOWARD H	YORK
MACDOUGALL, MD, JAMES H	ALLEGHENY
MACDOUGALL, MD, ROBERT D	YORK
MACEK, MD, ANNE L	PHILADELPHIA
MACEYKO, MD, RONALD F	CAMBRIA
MACFADYEN, MD, BRUCE V	PHILADELPHIA
MACHANIC, MD, HARMON J	LYCOMING
MACHIKO, MD, GREGORY G	WASHINGTON
MACHIRAJU, MD, V R	ALLEGHENY
MACHT JR, MD, ELMER L	PHILADELPHIA
MACIELAK, MD, JAMES R	CRAWFORD
MACK, MD, BRUCE J	BRADFORD
MACKALL, MD, SAMUEL J	LUZERNE
MACKELL, MD, JAMES V	PHILADELPHIA
MACKELL, MD, THOMAS E	BUCKS
MACKELL JR, MD, JAMES V	PHILADELPHIA
MACKELLAR, MD, BRUCE W	SUSQUEHANNA
MACKENZIE, MD, CHARLES E	WARREN
MACKENZIE, MD, IAIN L	YORK
MACKENZIE, MD, NORMAN D	CHESTER
MACKEY, JILL E	STUDENT
MACKEY JR, MD, JAMES G	MONTGOMERY
MACKIE, MD, JULIUS A	PHILADELPHIA
MACKINNEY, MD, CHARLES C	PHILADELPHIA
MACKLE, MD, EDWARD J	PHILADELPHIA
MACKLER, MD, GERALD L	BRADFORD
MACKRELL, MD, JAMES J	LACKAWANNA
MACKRELL, MD, JAMES P	ERIE
MACKRELL, MD, WILLIAM P	LACKAWANNA
MACLACHLAN, MD, WILLIAM W	ERIE
MACLAREN, MD, GEORGE A	MONTGOMERY
MACLAY, MD, PATRICIA L	ALLEGHENY
MACLEAR, DO, DOUGLAS G	CENTRE
MACLEOD, MD, GORDON K	ALLEGHENY
MACMILLAN, MD, JEFFREY T	ALLEGHENY
MACMORAN, MD, JAY W	PHILADELPHIA
MACNEEL, MICHAEL R	STUDENT
MACPHAIL, MD, JOHN A	WESTMORELAND
MACPHERSON, MD, TREVOR A	ALLEGHENY
MACUT, MD, S SAVA	DAUPHIN
MACVAUGH III, MD, HORACE	PHILADELPHIA
MACY, MD, CHARLES T	MONTGOMERY
MACZUGA, MD, CYNTHIA	LUZERNE
MADANY, MD, BAHIJ H	BUCKS
MADDEN, MD, FRANCIS P	BUCKS
MADDEN, MD, KEVIN G	LACKAWANNA
MADDEN, MD, ROBERT A	BUCKS
MADDEN, MD, STEPHANIE D	DAUPHIN
MADDEN JR, MD, HENRY J	ERIE
MADDEN JR, MD, LAWRENCE H	ALLEGHENY
MADDER, DO, DAVID A	PHILADELPHIA
MADDER, DO, ROBERT D	BEAVER
MADDOX, LISA M	STUDENT
MADEWELL, MD, JOHN E	DAUPHIN
MADHAVAN, MD, VASANTHA C	ALLEGHENY
MADIANOS, MD, EVAN F	PHILADELPHIA
MADIANOS, MD, MICHAEL	PHILADELPHIA
MADISETTY, MD, SUDHIR	MONROE
MADOFF, DAVID C	STUDENT
MADOFF, MD, HENRY R	ALLEGHENY
MADONNA, MD, FRANK A	BUTLER
MADONNA, MD, JOHN J	LEHIGH
MADOR, ANNE T	STUDENT
MADOW, MD, LEO	PHILADELPHIA
MADURA, MD, JOSEPH R	MERCER
MAENNER, MD, GERALD F	STUDENT
MAENZA, MD, RONALD M	PHILADELPHIA
MAERZ, MD, JOHN C	MONTGOMERY
MAFFEO, MD, ALPHONSE A	LEHIGH
MAGALSKI JR, JOPSEPH J	STUDENT
MAGARGAL, MD, HELGA O	PHILADELPHIA
MAGARGAL, MD, LARRY E	PHILADELPHIA
MAGARGEE, DO, SUSAN P	DELAWARE
MAGARGLE, MD, R LYNN	DAUPHIN
MAGBOJOS, MD, QUIRICO R	FRANKLIN
MAGBOJOS, MD, ZENAIDA V	FRANKLIN
MAGDALINSKI, DO, ANTHONY J	PHILADELPHIA
MAGEE, MD, JOAN M	CHESTER
MAGEE, MD, JOHN G	PHILADELPHIA
MAGEE, MD, JONI	PHILADELPHIA
MAGEE, MD, MICHAEL C	PHILADELPHIA
MAGEE, MD, RICHARD S	BLAIR
MAGGITTI, MD, MICHAEL J	CHESTER
MAGID, MD, D RIVA	MONTGOMERY
MAGID, MD, WARREN P	YORK
MAGIDA, MD, THEODORE M	PHILADELPHIA
MAGILL, MD, WILLIAM H	PERRY
MAGILL III, MD, JOHN T	UNION
MAGILNER, MD, ARTHUR D	PHILADELPHIA
MAGILNER, MD, LOUIS	PHILADELPHIA
MAGIT, MD, ANTHONY E	ALLEGHENY
MAGNESS, MD, KATHLEEN E	CHESTER
MAGOUN, MD, GEORGE L	ERIE
MAGOVERN, MD, GEORGE J	ALLEGHENY
MAGOVERN, MD, JAMES A	ALLEGHENY
MAGOVERN JR, MD, GEORGE J	ALLEGHENY
MAGRAN, MD, LEONARDO	PHILADELPHIA
MAGUIRE, DO, F WILLIAM	CHESTER
MAGUIRE, MD, JOSEPH I	DELAWARE
MAGUIRE, MD, JOSEPH I	DELAWARE
MAGUIRE, MD, LEO J	DELAWARE
MAGUIRE II, MD, FRANK P	LYCOMING
MAGYARITS, ELLEN M	STUDENT
MAHAJAN, MD, ANAND S	LANCASTER
MAHALINGAPPA, MD, C	WESTMORELAND
MAHAN, MD, JAMES C	ALLEGHENY
MAHAN, MD, JOHN P	BUCKS
MAHARAJH, MD, BALKISSOON A	CAMBRIA
MAHDIYAR, MD, ROZA	PHILADELPHIA
MAHER, MD, JOHN C	ALLEGHENY

MAHER, MD, JOHN P	CHESTER
MAHER, MD, REGIS M	FAYETTE
MAHER, MD, YVONNE B	ALLEGHENY
MAHER JR, MD, THOMAS D	ALLEGHENY
MAHIDHARA, MD, SESHU	ALLEGHENY
MAHMOOD, MD, ARSHAD	ALLEGHENY
MAHMOOD, MD, EDNA Z	BERKS
MAHMUD, MD, FARUQ	MONTOUR
MAHON, MD, MARILYN S	DAUPHIN
MAHON, MD, WILMER B	DAUPHIN
MAHON JR, MD, FRANK B	BRADFORD
MAHONY, MD, ELLEN A	MONTGOMERY
MAHOOD, MD, WILLIAM H	MONTGOMERY
MAHSOOB, MD, ABDUL HAMED	ALLEGHENY
MAIDA, MD, FRANK V	WESTMORELAND
MAIDEN, MD, PHILLIP G	MERCER
MAIER, MD, WILLIS P	PHILADELPHIA
MAIGUR, MD, WILLIAM S	LACKAWANNA
MAILMAN, MD, WENDY R	UNION
MAINGI, MD, NARESH S	DAUPHIN
MAINZER, MD, FRANCIS K	ERIE
MAIORANA, MD, S LEROY	BERKS
MAISEL, MD, WILFRED	NORTHAMPTON
MAISH JR, MD, GEORGE O	NORTHAMPTON
MAISSEL, MD, GERDA S	PHILADELPHIA
MAISTROW, MD, MARLA G	PHILADELPHIA
MAITIN, MD, ELLEN C	PHILADELPHIA
MAITLAND, MD, LEAH A	ADAMS
MAITRA, MD, SUBHASHIS	BLAIR
MAIVALD, MD, PAVEL	ALLEGHENY
MAJCHRZAK JR, CHARLES G	STUDENT
MAJDIC, DO, JAMES P	LUZERNE
MAJERNICK, DO, THOMAS G	WYOMING
MAJESKI, MD, JOSEPH T	LACKAWANNA
MAJMUDAR, MD, HARSHIT P	ALLEGHENY
MAJMUDAR, PARAG A	STUDENT
MAJMUDAR, MD, VASANTI H	ALLEGHENY
MAJOR, MD, DAVID A	PHILADELPHIA
MAKAROWSKI, MD, WILLIAM S	ERIE
MAKARY, MD, ADEL Z	MONTOUR
MAKDAD, MD, AMEENE G	WESTMORELAND
MAKHDOMI, MD, A RASHID	NORTHAMPTON
MAKHIJA, MD, KAILASH R	CARBON
MAKLER, MD, JACOB S	PHILADELPHIA
MAKLER JR, MD, P TODD	PHILADELPHIA
MAKOUS, MD, MONTE	MONTGOMERY
MAKOUS, MD, NORMAN	PHILADELPHIA
MAKSIMAK, MD, JANIS F	MONTOUR
MAKSIMAK, MD, MARTIN	MONTOUR
MALACARI, MD, DOMINIC V	LUZERNE
MALACOFF, MD, ROBERT F	NORTHAMPTON
MALAMUT, MD, RICHARD I	DELAWARE
MALASPINA, PAUL J	STUDENT
MALAYIL, MD, MICHAEL T	WASHINGTON
MALCOLM, MD, DONALD C	HUNTINGDON
MALCOLM JR, MD, JOHN A	UNION
MALCOM, MD, RONALD H	YORK
MALEK, MD, MANSOUR	PHILADELPHIA
MALEPATI, MD, DURGA	ALLEGHENY
MALEPATI, MD, VASU	GREENE
MALETA, VIVIANA M	STUDENT
MALEY, MD, EDWARD D	LANCASTER
MALEY, MD, RICHARD H	ALLEGHENY
MALHOTRA, MD, NARINDER K	ALLEGHENY
MALHOTRA, MD, RAJESHWAR P	MIFFLIN/JUNI
MALHOTRA, MD, SHASHPAL	MIFFLIN/JUNI
MALICK, MD, ALNOOR A	BRADFORD
MALICK, MD, DONALD V	SCHUYLKILL
MALICK, MD, GERALD P	BERKS
MALIK, MD, HUSSAIN G	MONROE
MALIK, MD, KHALID M	ARMSTRONG
MALIK, MD, MAQSOOD A	SCHUYLKILL
MALIK, MARIETTA A	STUDENT
MALIK, MD, RAJAT P	JEFFERSON
MALIK, MD, SHAKUNTALA M	JEFFERSON
MALIN, MD, THOMAS H	DAUPHIN
MALINIAK, MD, KEITH K	DAUPHIN
MALINOWSKI, MD, JOHN A	ALLEGHENY
MALISHAUCKI, MD, MARY G	SCHUYLKILL
MALIT, MD, FIORELLO G	ALLEGHENY
MALIT, MD, LEE A	MONTGOMERY
MALIT, MD, PAULITA Y	ALLEGHENY
MALIVER, MD, DEBORAH S	INDIANA
MALIVER, MD, LEONARD E	INDIANA
MALJOVEC, MD, JOSEPH J	WARREN
MALKIN, MD, ALAN G	PHILADELPHIA
MALKIN, MD, RICHARD L	PHILADELPHIA
MALKOWICZ, MD, STANLEY B	PHILADELPHIA
MALL, MD, ALBERT K	CAMBRIA
MALLAVARAPU, MD, CHRISTOPHER T	PHILADELPHIA
MALLEY, ERIN E	STUDENT
MALLINGER, MD, MARK L	ALLEGHENY
MALLINGER, MD, MICHAEL	ALLEGHENY
MALLINGER, MD, SAMUEL H	BEAVER
MALLIS, MD, NEIL J	PHILADELPHIA
MALLOTT, MD, I FLOYD	ALLEGHENY
MALLOY, MD, EDWARD L	ALLEGHENY
MALLOY, MD, EDWIN S	LACKAWANNA
MALLOY, MD, TERRENCE R	PHILADELPHIA
MALLOY, MD, WALTER N	LYCOMING
MALMUD, MD, LEON S	PHILADELPHIA
MALOLES JR, MD, ORLANDO Z	DELAWARE
MALONE, JAMES P	STUDENT
MALONE, MD, WILLIAM J	MONTOUR
MALONEY, MD, DONALD W	MONTGOMERY
MALONEY, MD, RICHARD W	ERIE
MALPANI, MD, AJAY R	DAUPHIN
MALSCH, MD, EVAMARIE	PHILADELPHIA
MALTZMAN, JONATHAN S	STUDENT
MALUMED, MD, JEFFREY	DELAWARE
MALVAR, MD, THOMAS Q	LAWRENCE
MALVICA, MD, ROBERT P	BRADFORD
MAMA, SAIFUDDIN T	STUDENT
MAMBU, MD, JOSEPH F	MONTGOMERY
MAMROS, MD, MARK A	WASHINGTON
MAMULA, MD, MILTON	ALLEGHENY
MANASSE, MD, HOWARD S	ERIE
MANCALL, MD, ELLIOTT L	PHILADELPHIA
MANCANO, MD, LOUIS D	MONTGOMERY
MANCHESTER, MD, GEORGE A	LYCOMING
MANCIA, MD, BONITA M	LUZERNE
MANCINI, MD, ALFRED M	ALLEGHENY
MANCINI, MD, DAVID A	MONTGOMERY
MANCINO, MD, PETER J	LAWRENCE
MANCUSO, CHRISTOPHER J	STUDENT
MANDAK, MD, JEFFREY S	PHILADELPHIA
MANDAL, MD, SANAT K	PHILADELPHIA
MANDALAKAS, MD, NICHOLAS J	LANCASTER
MANDARINO, MD, MICHAEL J	PHILADELPHIA
MANDEL, MD, MARTIN M	PHILADELPHIA
MANDEL, MD, MICHAEL	LUZERNE
MANDEL, MD, ROBERT J	DAUPHIN
MANDEL, MD, STEVEN	PHILADELPHIA
MANDELKORN, MD, ROBERT M	ALLEGHENY
MANDELL, MD, ANDREW	LUZERNE
MANDELL, MD, MICHAEL J	DAUPHIN
MANDELL, MD, MORTON S	PHILADELPHIA
MANDERS, MD, ERNEST K	DAUPHIN
MANDETTA, MD, DONALD F	CENTRE
MANDLER, MD, JOHN I	MONTGOMERY
MANEJWALA, MD, FAZAL M	STUDENT
MANFREY, DO, FRANK J	MONTGOMERY
MANFREY, DO, SAMUEL J	MONTGOMERY
MANG, MD, HENRY Y	ALLEGHENY
MANGAN, MD, THOMAS F	MONTOUR
MANGANARO, MD, KIMBERLY J	MIFFLIN/JUNI
MANGANIELLO, MD, CHARLES M	LUZERNE
MANGE, KEVIN C	STUDENT
MANGES, MD, JOHN P	FRANKLIN
MANGOLD, MD, DANIEL S	PHILADELPHIA
MANHOFF, MD, DION T	PHILADELPHIA
MANI, MD, SHOBHA T	PHILADELPHIA
MANIFOLD, STEVE G	STUDENT
MANIGLIA, MD, ANGELO J	BLAIR
MANIGLIA, MD, ANTHONY J	BLAIR
MANIGLIA, MD, RICHARD J	MONTGOMERY
MANIGLIA, MD, ROSARIO	DAUPHIN
MANJON, MD, JOSE M	DAUPHIN
MANJONEY, MD, DEBORAH L	ERIE
MANKO, MD, MICHAEL A	MONTGOMERY
MANKOVICH, MD, PAUL A	WESTMORELAND
MANLEY, MD, DONELSON R	PHILADELPHIA
MANLOVE, MD, FRANCIS R	PHILADELPHIA
MANN, MD, DENISE L	PHILADELPHIA
MANN, MD, DOUGLAS G	DELAWARE
MANN, MD, IRVING A	DELAWARE
MANN, MD, ORRIN	BEAVER
MANN, MD, RICHARD M	ALLEGHENY
MANN, MD, ROBERT J	MONTGOMERY
MANN, RONALD M	STUDENT
MANN, THOMAS A	STUDENT
MANN JR, MD, DAVID E	YORK
MANNARINO, MD, ANTHONY P	BUCKS
MANNELLA, JOSEPH J	STUDENT
MANNELLA, MD, WILLIAM J	DELAWARE
MANNES, MD, ANDREW J	PHILADELPHIA
MANNHEIMER, ALAN L	STUDENT
MANNING, MD, ANNE M	DAUPHIN
MANNING, MD, DENNIS M	ALLEGHENY
MANNING, MD, FRANCIS J	PHILADELPHIA
MANNING, MD, HARRY L	LYCOMING
MANNING, MD, JAMES A	ALLEGHENY
MANNING, MD, JAMES A	YORK
MANNING, MD, RICHARD G	DAUPHIN
MANNING, MD, RUSSELL G	JEFFERSON
MANNINO, MD, STANLEY C	ALLEGHENY
MANNION, MD, JOHN D	PHILADELPHIA
MANNISI, MD, JOHN A	NORTHAMPTON
MANNO JR, MD, BRUNO V	PHILADELPHIA
MANOLUKAS, DO, PETER G	BEAVER
MANRIQUE, MD, JOSE V	LUZERNE
MANSELL, MD, JOHN L	LAWRENCE
MANSFIELD, MD, CARL M	PHILADELPHIA
MANSTEIN, MD, CARL H	PHILADELPHIA
MANSTEIN, MD, GEORGE	PHILADELPHIA
MANSTEIN, MD, JOANNE L	MONTGOMERY
MANSTEIN, MD, MARK E	PHILADELPHIA
MANSURE, MD, FRANK T	DELAWARE
MANTIA, MD, AUGUST M	ALLEGHENY
MANTICA, MD, ROBERT P	BEAVER
MANUBAY, MD, JOHN A	YORK
MANUBAY, MD, JOHN M	BERKS
MANUBAY, MD, MARCELO A	BERKS
MANUEL, MD, LAUREANO M	COLUMBIA
MANUS, MD, NATHAN	PHILADELPHIA
MANZELLA, MD, JOHN P	YORK
MANZETTI, MD, GENE W	ALLEGHENY
MANZIONE, MD, MARC	MONTGOMERY
MANZO, MD, THOMAS L	MONTGOMERY
MANZONE, MD, TIMOTHY A	DELAWARE
MAO, MD, NANCY A	LEHIGH
MAQUERA, MD, ANDRE G	LEHIGH
MARAGOS, STAVROS G	STUDENT
MARAKOWSKI, DO, JAMES J	PERRY
MARASCO JR, MD, JOSEPH A	ALLEGHENY
MARATTA, MD, JAN W	ALLEGHENY
MARAVALLI, MD, CAMILLE J	CAMBRIA
MARBACH, MD, A HERBERT	PHILADELPHIA
MARCELIS, MD, JOHN F	PHILADELPHIA
MARCELLA, MD, LAWRENCE C	LAWRENCE
MARCELLA, MD, STEPHEN W	LUZERNE
MARCELO, MD, FLORDELIZA S	PHILADELPHIA
MARCH, MD, HERMAN C	MONTGOMERY
MARCHANT, MD, ERIC A	BUCKS
MARCHETTO, MD, PAUL A	PHILADELPHIA
MARCHINSKI, MD, LEONARD J	BERKS
MARCIANO, MD, JULIET A	BUCKS
MARCINCIN, MD, PAUL G	NORTHAMPTON
MARCINCIN, MD, ROBERT P	NORTHAMPTON
MARCONIS, MD, JOSEPH T	SCHUYLKILL
MARCOUX, MD, ANNE-MARIE C	BUCKS
MARCUCCI, MD, JAMES W	ALLEGHENY
MARCUCCI, MD, MICHAEL C	PHILADELPHIA
MARCUS, MD, CRAIG H	PHILADELPHIA
MARCUS, MD, DONALD J	CHESTER
MARCUS, MD, DONALD K	PHILADELPHIA
MARCUS, MD, FLORENCE L	ALLEGHENY
MARCUS, MD, GARY J	BEAVER
MARCUS, MD, JEROME I	BERKS
MARCUS, MD, MICHAEL N	PHILADELPHIA
MARCY, MD, JOSEPH H	ALLEGHENY
MARDAYAT, MD, MAULANA	BEDFORD
MARDEN, MD, PHILIP A	PHILADELPHIA
MARFATIA, MD, SUDHIR K	BUCKS
MARFATIA, MD, USHA S	BUCKS
MARGARIDA, MD, LEOPOLDO E	MONTGOMERY
MARGATE, MD, PEDRO R	PHILADELPHIA
MARGIE III, MD, WALTER E	BRADFORD
MARGIE JR, MD, WALTER E	NORTHAMPTON
MARGOLES, MD, LOUIS	PHILADELPHIA
MARGOLIS, MD, BERNARD	PHILADELPHIA
MARGOLIS, MD, BERNARD M	DAUPHIN
MARGOLIS, MD, DAVID J	PHILADELPHIA
MARGOLIS, MD, HARRY M	ALLEGHENY
MARGOLIS, MD, NORA M	PHILADELPHIA
MARGOLIS, MD, STEPHEN H	PHILADELPHIA
MARGOLIS, MD, THOMAS I	PHILADELPHIA
MARGRAF, MD, JOHN W	LEHIGH
MARGUGLIO, DO, A EUGENE	CLARION
MARI-MAYANS, MD, JUAN B	WESTMORELAND
MARIANI, MD, STEPHEN S	LACKAWANNA
MARIANO JR, MD, BENEDICTO F	WESTMORELAND
MARIANO JR, MD, TOMAS A	LYCOMING
MARICI, KENNETH F	STUDENT
MARIGLIO, MD, JOSEPH A	BERKS
MARINARO, MARIA	STUDENT
MARINELLI, RICCARDO R	STUDENT
MARINER, MD, DAVID R	LUZERNE
MARINI, MD, CORRADO P	DAUPHIN
MARINO, MD, DANIEL J	DELAWARE
MARINO, MD, GLEN A	SCHUYLKILL
MARINO, MD, JOSEPH N	LACKAWANNA
MARINO, MD, MARK	CHESTER
MARINO, MD, RALPH	PHILADELPHIA
MARINO, MD, REINA A	PHILADELPHIA
MARINO, DO, THOMAS N	CHESTER
MARINO JR, MD, LOUIS J	ALLEGHENY
MARINSTEIN, MD, RHEA L	ALLEGHENY
MARION, MD, DONALD W	ALLEGHENY
MARION, MD, ROY H	BEAVER
MARIOTTI, DO, LOUIS J	PHILADELPHIA
MARK, MD, GEORGE E	PHILADELPHIA
MARK, MD, WILLIAM S	CHESTER
MARKAKIS, MD, DOROTHEA A	PHILADELPHIA
MARKARIAN, MD, MICHAEL	SUSQUEHANNA
MARKHAM JR, MD, DEAN F	BRADFORD
MARKIEWICZ, MD, ANN M	DAUPHIN
MARKLEY, MD, RALPH	LAWRENCE
MARKMANN, MD, WILLIAM J	PHILADELPHIA
MARKOFF, MD, JOSEPH I	PHILADELPHIA
MARKOVITZ, MD, BRUCE J	MONTGOMERY
MARKOVITZ, MD, JEROME H	ALLEGHENY
MARKOW, MD, HARRY G	PHILADELPHIA
MARKOWITZ, MD, GARY D	MONTGOMERY
MARKOWITZ, MD, HANK E	LAWRENCE
MARKOWSKI, MD, WILLIAM J	PHILADELPHIA
MARKS, MD, GERALD	PHILADELPHIA
MARKS, MD, MEYER A	PHILADELPHIA
MARKS, MD, STANLEY M	ALLEGHENY
MARKS, MD, VICTOR J	MONTOUR
MARKS TABBY, MD, SARA	PHILADELPHIA
MARKSON, MD, VICTOR I	BEAVER
MARLAPUDI, MD, PREM K	BUCKS
MARLOWE, MD, FRANK I	PHILADELPHIA
MARLOWE, MD, JENNIFER O	MONTGOMERY
MARLOWE, MD, SCOTT D	PHILADELPHIA
MARMAR, MD, EARL C	PHILADELPHIA
MARMO, MD, THEODORE	LACKAWANNA
MARNATTI, MD, CARL T	ALLEGHENY
MARON, MD, JOHN J	MONTGOMERY
MARON, MD, NORMAN L	NORTHAMPTON
MARONE, MD, PHILLIP J	PHILADELPHIA
MAROON, MD, JOSEPH C	ALLEGHENY
MAROON, MD, MICHELE S	MONTOUR
MAROON, MD, THOMAS J	WESTMORELAND
MAROPIS, MD, CHRISTOPHER G	ALLEGHENY
MARQUART, CHRISTINE A	STUDENT
MARQUEZ, MD, MANUEL S	PHILADELPHIA
MARQUEZ, MD, PEDRO A	FAYETTE
MARQUIS, MARIAN K	STUDENT
MARR, BRIAN P	STUDENT
MARR, KAREN A	STUDENT
MARRANGONI, MD, ALBERT G	ALLEGHENY
MARRERO, MD, CARLOS J	WESTMORELAND
MARRERO, MD, CHRISTOPHER E	PHILADELPHIA
MARRERO, MD, LUIS B	MCKEAN
MARRONE, MD, MICHAEL S	LEBANON
MARRYSHOW, MD, BASIL A	ALLEGHENY
MARSH, MD, CAROL L	CHESTER
MARSHALL, MD, DAVID S	SCHUYLKILL
MARSHALL, MD, E WAYNE	PHILADELPHIA
MARSHALL, MD, HELEN L	SCHUYLKILL
MARSHALL, MD, JACK H	ERIE
MARSHALL, MD, JANE M	VENANGO
MARSHALL, MD, JOHN E	BERKS
MARSHALL, MD, JOHN F	MONTOUR
MARSHALL, MD, JOHN S	BEAVER
MARSHALL, DO, LONNIE L	ALLEGHENY
MARSHALL, RENEE L	STUDENT
MARSHALL, DO, SHEILA F	BEAVER
MARSHALL, MD, WAYNE K	DAUPHIN
MARSHALL, MD, WILLIAM C	ALLEGHENY
MARSHALL JR, MD, MATTHEW	ALLEGHENY
MARSICO, DO, DOMINIC E	DELAWARE
MARTE, MD, EGON	DAUPHIN
MARTELL JR, MD, JOHN R	ALLEGHENY
MARTELLA, CHRISTOPHER W	STUDENT
MARTENS, MD, JEFFREY D	STUDENT
MARTHOUSE, MD, STEPHEN J	MIFFLIN/JUNI
MARTIDIS, ADAM	STUDENT
MARTIN, BERNARD G	STUDENT
MARTIN, MD, C EDWIN	YORK
MARTIN, MD, DAVID C	WESTMORELAND
MARTIN, MD, DONALD E	LEBANON
MARTIN, MD, EDWARD T	PHILADELPHIA
MARTIN, DO, ELVIN L	SOMERSET
MARTIN, MD, FREDERICK H	LEHIGH
MARTIN, MD, FREDRIC W	ALLEGHENY
MARTIN, MD, GERALD B	CUMBERLAND
MARTIN, MD, HORACE F	ADAMS
MARTIN, MD, J CAMPBELL	COLUMBIA
MARTIN, MD, J SCOTT	MONTOUR
MARTIN, MD, JAMES J	LACKAWANNA
MARTIN, JAMES S	STUDENT
MARTIN, MD, JAMES W	CRAWFORD
MARTIN, MD, JAMES W	ALLEGHENY
MARTIN, MD, JEFFREY A	WAYNE/PIKE
MARTIN, MD, JOHN H	MONTGOMERY
MARTIN, DO, LAURA M	LUZERNE
MARTIN, MD, LOUIS F	DAUPHIN
MARTIN, MD, MANUEL T	ALLEGHENY
MARTIN, MD, MARTINA M	MONTGOMERY
MARTIN, MD, MARYANNE	BLAIR
MARTIN, MD, MELANIE C	MONTGOMERY
MARTIN, MD, NANCY J	STUDENT
MARTIN, MD, RONALD C	CRAWFORD
MARTIN, MD, THOMAS J	MONTOUR
MARTIN, EXEC DIRECTOR, PATRICIA A	LACKAWANNA
MARTIN JR, MD, C EDWIN	YORK
MARTIN JR, MD, JOHN A	BERKS
MARTIN JR, MD, JOHN B	WASHINGTON
MARTINA, DO, PETER A	WASHINGTON
MARTINELLI, MD, JOSEPH A	STUDENT
MARTINES, DO, RICHARD	BRADFORD
MARTINEZ, MD, AUGUSTO J	ALLEGHENY
MARTINEZ, MD, IRISAIDA	PHILADELPHIA
MARTINEZ, MD, JESS M	WASHINGTON
MARTINEZ, MD, JORGE A	ALLEGHENY
MARTINEZ, MANUEL A	STUDENT
MARTINEZ, MD, ZEFERINO	BERKS
MARTINI, MD, ENRICO E	LANCASTER
MARTINI, MD, MARY C	ALLEGHENY
MARTINI, MD, VICTOR S	ERIE
MARTINSON, MD, MARK W	MONTOUR
MARTONE, MD, CHRISTINE	ALLEGHENY
MARTONE, MD, LOUIS H	ALLEGHENY
MARTSOLF, MD, JOHN	BEAVER
MARTSOLF, MD, ROBERT H	MERCER
MARTUCCI, MD, JOHN J	MONROE
MARTYAK, DO, GABRIEL S	BRADFORD
MARTYAK, MD, NICHOLAS A	LUZERNE
MARTYN, MD, LOIS J	PHILADELPHIA
MARTYNEC, MD, BOHDAN	BUCKS
MARTYNIUK, MD, JOHN W	MONROE
MARTZ, MD, MARK N	LEHIGH
MARVA, MD, DONALD J	PHILADELPHIA
MARVI, MD, DAVOUD	LEHIGH
MARVIN, MD, ROBERT F	DELAWARE
MARWAHA, MD, ASHA	BUTLER
MARX, MD, KENNETH W	BERKS
MARX, MD, MARVIN H	MONTGOMERY
MARYMOR, MD, NEIL S	MONTGOMERY
MARYNIAK, MD, GIRARD M	BERKS
MARZANO, MD, JOSEPH A	PHILADELPHIA
MARZIANO, MICHELE L	STUDENT
MARZO, MD, KEVIN P	PHILADELPHIA
MASANKAY, MD, MANUEL G	LACKAWANNA
MASCERI, MD, STEPHEN J	PHILADELPHIA
MASCHKE, MD, STUART P	YORK
MASCIANGELO, MD, THOMAS N	ALLEGHENY
MASCIOTRA, MD, NICHOLAS J	CAMBRIA
MASH, MD, MARLENE J	MONTGOMERY
MASH, MD, MICHAEL J	MONTGOMERY
MASIN, MD, F NED	ALLEGHENY
MASLAND, MD, DAVID S	CUMBERLAND
MASLOFF, MD, MELVIN L	PHILADELPHIA
MASLOV, MD, MARC D	VENANGO
MASON, AARON C	STUDENT
MASON, MD, CHARLES E	VENANGO
MASON, MD, DANIEL	PHILADELPHIA
MASON, REGINALD K	STUDENT
MASONE, MD, ANTHONY J	ALLEGHENY
MASS, SHARON B	STUDENT
MASSARI, MD, FERDINAND E	MONTGOMERY
MASSELLA, MD, ELIZABETH L	ALLEGHENY
MASSENGALE, MD, ALEXANDER T	BERKS
MASSEY, MD, GORDON J	ERIE
MASSIE, MD, MITCHELL T	ALLEGHENY
MASSUCCI, MD, JAMES E	ALLEGHENY
MAST, DO, DANIEL D	BUCKS

MAST, MD, TRUMAN E	LANCASTER
MASTANDREA, MD, CARL A	ALLEGHENY
MASTER, MD, KENNETH V	PHILADELPHIA
MASTERS, MD, RAYMOND E	ALLEGHENY
MASTERS, MD, RUTH S	ALLEGHENY
MASTERS, DO, THOMAS R	ERIE
MASTERSON, DO, JAMES N	WESTMORELAND
MASTRIAN, MD, ANTHONY S	LAWRENCE
MASTRINE, MD, LARRY R	CAMBRIA
MASUCCI, MD, DOUGLAS J	YORK
MASUD, MD, FAISAL N	BUCKS
MATADAR, MD, AKBAR G	ALLEGHENY
MATAREBE, MD, EMIL L	BUCKS
MATEER, MD, FRANK	ALLEGHENY
MATEER, MD, JOHN E	CENTRE
MATEER JR, MD, HARRY O	SCHUYLKILL
MATEYA, MD, DENNIS J	ALLEGHENY
MATHAI, MD, JOHN	YORK
MATHEW, MD, ANNA	ALLEGHENY
MATHEWS, DO, JAMES C	BUTLER
MATHEWS, MD, ROBERT A	PHILADELPHIA
MATHEWS, MD, ROBERT S	LANCASTER
MATHEWS JR, MD, NEILSON M	MONTGOMERY
MATHIAS, MENEN A	STUDENT
MATHIS, MD, JAMES G	BERKS
MATHIS, MD, JERRY L	BLAIR
MATHOS, DO, THOR C	ALLEGHENY
MATHUR, MD, AJAY K	ALLEGHENY
MATHUR, MD, DINESH P	CAMBRIA
MATHUR, MD, KAILASH	SCHUYLKILL
MATLIN, DO, EMILY W	DAUPHIN
MATRAGRANO, MD, ANDREW P	MONTOUR
MATSKO, MD, JANE R	BERKS
MATSKO, MD, JANINE A	PHILADELPHIA
MATSKO, MD, MICHAEL E	LUZERNE
MATSKO, DO, ROBERT P	PERRY
MATSUMOTO, MD, TERUO	PHILADELPHIA
MATSUURA, DEAN H	STUDENT
MATTA, DO, ROBERT A	LEHIGH
MATTA, MD, SHOUKRY	LAWRENCE
MATTEI, MD, FRANK A	PHILADELPHIA
MATTEUCCI, MD, WALTER V	PHILADELPHIA
MATTHEWS, MD, GEORGE R	BERKS
MATTHEWS, MD, WARREN B	MONTGOMERY
MATTHEWS, WILLIAM E	STUDENT
MATTHEWS JR, MD, TED A	WESTMORELAND
MATTIACE, MD, WILLIAM J	LYCOMING
MATTLEMAN, DO, JOEL H	LANCASTER
MATTLEMAN, MD, STEVEN J	PHILADELPHIA
MATTSON, MD, RONALD J	MONTGOMERY
MATULEWSKI, MD, THOMAS J	DELAWARE
MATUNIS, MD, JOSEPH J	PERRY
MATUS, MD, NANCY R	NORTHAMPTON
MATZELLE, MD, DONALD W	FRANKLIN
MATZKO, MD, JOHN	YORK
MAUPIN, MD, KEVIN D	VENANGO
MAUR, MD, GURPREET S	ALLEGHENY
MAURER, MD, CAROL N	VENANGO
MAURER, MD, PHILIP M	PHILADELPHIA
MAURIELLO, DO, CHARLES A	PHILADELPHIA
MAURO, MD, KIRK J	ALLEGHENY
MAUS, MD, MARLON T	PHILADELPHIA
MAUST, MD, PAUL E	BUTLER
MAUTHE, MD, ROBERT W	NORTHAMPTON
MAX, MD, MARTIN H	CAMBRIA
MAXIAN, DO, JOSEPH A	BUCKS
MAXIN, MD, CHARLES W	CENTRE
MAXSON JR, MD, CHESTER J	PHILADELPHIA
MAXWELL, MD, BETH A	WESTMORELAND
MAXWELL, MD, DORIS B	WESTMORELAND
MAXWELL, MD, EMILIE L	MONTGOMERY
MAXWELL, DO, STEVEN J	MONROE
MAXWELL, DO, STEVEN L	DAUPHIN
MAXWELL JR, MD, HENRY L	ADAMS
MAXWELL JR, MD, ROBERT A	MONTGOMERY
MAY, HELEN	STUDENT
MAY, MD, JOHN C	LANCASTER
MAY, MD, MARK M	ALLEGHENY
MAY, MD, ROBERT E	PHILADELPHIA
MAY JR, MD, KENNETH J	DAUPHIN
MAYBERRY, MD, JAMES C	ALLEGHENY
MAYBERRY, DO, JOSEPH J	LANCASTER
MAYDONOVITCH, DO, DANIEL J	MONTGOMERY
MAYER, MD, BERNARD W	MONTGOMERY
MAYER, MD, DAVID P	PHILADELPHIA
MAYER, MD, HENRY S	MONTGOMERY
MAYER, MD, NATHANIEL H	PHILADELPHIA
MAYER, O HENRY	STUDENT
MAYER, MD, ROBERT A	CHESTER
MAYERBERGER, MD, SCOTT A	PHILADELPHIA
MAYERNIK, MD, DAVID G	ALLEGHENY
MAYERS JR, MD, STANLEY P	CENTRE
MAYLATH, CRAIG F	STUDENT
MAYLOCK, CAROLINE A	STUDENT
MAYLOCK, MD, JOHN H	BEDFORD
MAYLOCK, JOHN V	STUDENT
MAYO, MD, EDITH A	DELAWARE
MAYOCK, MD, ROBERT L	PHILADELPHIA
MAYRO, MD, JULIAN	PHILADELPHIA
MAYRO, MD, LESLIE B	ALLEGHENY
MAYS, MD, RICHARD R	LYCOMING
MAYS, WARREN L	STUDENT
MAZAHERI, MD, AHMED	BUCKS
MAZDA, DO, RUSSELL F	LANCASTER
MAZER, MD, HOWARD	PHILADELPHIA
MAZERO, MD, JOHN R	WESTMORELAND
MAZGAJ, MD, JAMES P	YORK
MAZICH, MD, THERESA E	BUCKS
MAZUR, DONALD W	STUDENT
MAZUZ, MD, MEIR	BERKS
MAZZA, MD, DOMINIC L	LACKAWANNA
MAZZA, MD, JOSEPH L	ALLEGHENY
MAZZA, MD, PATRICK A	BERKS
MAZZACCO, STACEY L	STUDENT
MAZZEI, MD, JOSEPH M	ALLEGHENY
MAZZONE, MD, MICHAEL F	STUDENT
MC ALLISTER, MD, JOSEPH C	MONTGOMERY
MC BREARTY, MD, FRANCIS X	DELAWARE
MC CLURE, MD, JONATHAN K	BEAVER
MC CLUSKEY, MD, LEO F	PHILADELPHIA
MC DONALD, DO, GREGORY	DELAWARE
MC DONALD, MD, MICHAEL A	BUTLER
MC ELFRESH, MD, CHARLES W	MONTGOMERY
MC GAUGHRAN, MD, ALAN L	JEFFERSON
MC GEHEE, MD, EDWARD H	PHILADELPHIA
MC GOWAN, MD, DAVID G	PHILADELPHIA
MC GUIRE, MD, BIRGITTA T	CRAWFORD
MC GUIRE, MD, MICHAEL D	MONTGOMERY
MC HARG, MD, MALCOLM L	MONTGOMERY
MC HUGH, CHRISTINA M	STUDENT
MC KEOWN JR, MD, JOHN J	PHILADELPHIA
MC LAUGHLIN JR, DO, WILLIAM M	LUZERNE
MC NIESH, MD, LAWRENCE M	CAMBRIA
MC TIGHE, MD, ARTHUR H	UNION
MCADAMS, MD, ANDREW J	ALLEGHENY
MCADAMS, PAUL D	STUDENT
MCAFOOS, MD, GARY L	WARREN
MCAFOOS, MD, J ALLEN	ALLEGHENY
MCALEER, MD, DAVID J	DELAWARE
MCALLISTER, MD, HELEN B	PHILADELPHIA
MCALLISTER, MD, JOHN D	ALLEGHENY
MCALLISTER II, MD, JOHN D	ALLEGHENY
MCANDREW, MD, JOHN J	LACKAWANNA
MCANDREW, DO, PATRICK J	LACKAWANNA
MCARDLE, MD, DAVID Q	CAMBRIA
MCARDLE, MD, GILBERT C	ADAMS
MCARDLE, MD, M JACQUELYN	ADAMS
MCAULIFFE, MD, THOMAS C	PHILADELPHIA
MCAVOY, MD, WILLIAM B	ALLEGHENY
MCBETH JR, MD, ORVILLE G	ADAMS
MCBRIDE, DAVID R	STUDENT
MCBRIDE, MD, JAMES G	NORTHAMPTON
MCBRIDE, KEVIN B	STUDENT
MCBRIDE, MD, THOMAS J	DELAWARE
MCBRYAN JR, DONALD J	STUDENT
MCCABE, MD, JAMES L	MONTGOMERY
MCCABE, MD, JOHN S	WASHINGTON
MCCABE, MD, PAUL H	DAUPHIN
MCCADDEN, MD, JOSEPH A	DELAWARE
MCCAFFERTY, MD, JOHN P	PHILADELPHIA
MCCAFFERTY, MD, LEO R	ALLEGHENY
MCCAFFERTY, MD, MICHAEL H	ALLEGHENY
MCCAGUE, MD, NED J	ALLEGHENY
MCCAHAN, MD, WESLEY F	BEDFORD
MCCAIRNS, MD, ROBERT G	PHILADELPHIA
MCCALL, MD, WILLIAM M	DAUPHIN
MCCANDLESS, MD, DAVID P	VENANGO
MCCANDLESS, MD, WARREN J	VENANGO
MCCANN, MD, WILLIAM D	LANCASTER
MCCANS, MD, KATHRYN M	DELAWARE
MCCARRON, MD, DANIEL J	PHILADELPHIA
MCCARTER, MD, PAMELA F Y	MIFFLIN/JUNI
MCCARTER JR, MD, THOMAS G	STUDENT
MCCARTHY, DO, BRYAN S	PHILADELPHIA
MCCARTHY, JAMES M	STUDENT
MCCARTHY, DO, MATTHEW T	ERIE
MCCARTHY III, MD, JOHN J	ALLEGHENY
MCCARTNEY, MD, LESTER D	ERIE
MCCARTNEY, MD, RONALD L	ERIE
MCCASLIN, TODD A	STUDENT
MCCAULEY, MD, WILLIAM C	LYCOMING
MCCAUSLAND, MD, PAUL J	DELAWARE
MCCENSKY, MD, GAIL M	ALLEGHENY
MCCHESNEY JR, MD, CHARLES T	CHESTER
MCCLAIN, MD, CHARLES B	MIFFLIN/JUNI
MCCLAIN, DO, DIANE M	BLAIR
MCCLAIN JR, MD, EDWARD J	ALLEGHENY
MCCLELLAN, MD, R MICHAEL	DELAWARE
MCCLENATHAN, MD, JAMES E	ADAMS
MCCLINTIC, DO, WILLIAM R	BRADFORD
MCCLINTOCK, MD, W CREIGHTON	ALLEGHENY
MCCLOSKEY, MD, DAVID S	DELAWARE
MCCLOSKEY, MD, RICHARD C	ALLEGHENY
MCCLOSKEY, MD, RICHARD V	PHILADELPHIA
MCCLOSKEY, MD, SISTER ANN M	SCHUYLKILL
MCCLOSKEY, DO, TIMOTHY J	LYCOMING
MCCLOWRY, MD, JAMES T	ALLEGHENY
MCCLOY, MD, MERRITT J	WESTMORELAND
MCCLUNG, MD, LARRY S	WESTMORELAND
MCCLURE, MD, JAMES E	SUSQUEHANNA
MCCLURE, MD, THOMAS A	ALLEGHENY
MCCLURE, MD, THOMAS D	WESTMORELAND
MCCLURKEN, MD, JAMES B	MONTGOMERY
MCCOLLUM, MD, GEORGE R	ALLEGHENY
MCCOMBS, MD, ELAINE M	MONTGOMERY
MCCOMBS, MD, PETER R	MONTGOMERY
MCCOMBS, MD, RAY D	ERIE
MCCONAGHY, MD, JOHN R	ALLEGHENY
MCCONAHY, MD, JOHN G	LAWRENCE
MCCONNEL JR, MD, CHARLES S	LEHIGH
MCCONNELL, MD, BRIAN A	STUDENT
MCCONNELL JR, MD, EDWARD L	PHILADELPHIA
MCCONVILLE, MD, JOHN H	YORK
MCCORD, MD, JAMES A	MONTGOMERY
MCCORMACK, MD, PATRICIA A	LACKAWANNA
MCCORMACK, MD, THOMAS M	PHILADELPHIA
MCCORMICK, DO, ALICE	WAYNE/PIKE
MCCORMICK, DO, DANIEL J	PHILADELPHIA
MCCORMICK, MD, GEORGE M	CENTRE
MCCORMICK, MD, JOHN L	PHILADELPHIA
MCCORMICK, MD, JOHN V	MONTOUR
MCCORMICK, MD, LEE H	ALLEGHENY
MCCORMICK, DO, RICHARD C	LYCOMING
MCCORVEY, V MONIQUE	STUDENT
MCCOY, MD, ANDREA C S	DAUPHIN
MCCOY, MD, ROBERT L	NORTHAMPTON
MCCOY, MD, THOMAS D	INDIANA
MCCOY III, MD, WILLIAM H	ALLEGHENY
MCCOY JR, MD, GEORGE W	NORTHAMPTON
MCCREARY III, MD, THOMAS W	BEAVER
MCCULLOUGH JR, MD, JAMES L	LEHIGH
MCCUNE, MD, ANN B	ALLEGHENY
MCCUNE, MD, WALLACE G	PHILADELPHIA
MCCURDY, MD, DINO E P	PHILADELPHIA
MCCURDY, MD, RICHARD R	DELAWARE
MCCUSKER, MD, FRANCIS X	MONTGOMERY
MCCUSKEY, MD, WILLIAM H	ALLEGHENY
MCDANIEL-TURNER, MD, ANNETTE S	PHILADELPHIA
MCDERMIT, MD, JOHN R	PHILADELPHIA
MCDERMOTT, MD, ROBERT W	ALLEGHENY
MCDONALD, MD, DONALD J	PHILADELPHIA
MCDONALD, MD, HERBERT M	LACKAWANNA
MCDONALD, JEROME M	STUDENT
MCDONALD, MD, KENNETH M	LEHIGH
MCDONALD, MD, MARILYN R	NORTHAMPTON
MCDONALD JR, DO, JAMES F	PHILADELPHIA
MCDONALD JR, MD, ROBERT H	ALLEGHENY
MCDONALD JR, MD, THOMAS J	BRADFORD
MCDONNELL-DATTILO, MD, COLLEEN	ALLEGHENY
MCDONOUGH, MD, GERARD A	LEHIGH
MCDONOUGH, MD, KATHLEEN M	LANCASTER
MCDOUGALL, MD, WILLIAM A	ALLEGHENY
MCDOWELL, MD, EDWARD P	INDIANA
MCDOWELL, MD, MARY J	ALLEGHENY
MCDOWELL, MD, RICHARD M	CAMBRIA
MCDOWELL, DO, WILLIAM G	MERCER
MCELRATH, JAMIE R	STUDENT
MCELREE, MD, JAMES C	MERCER
MCELREE JR, MD, FRANK E	MERCER
MCELROY, MD, PHILIP K	MONTGOMERY
MCEVOY, MD, ROBERT F	NORTHAMPTON
MCFADDEN, MD, DEBRA R	WESTMORELAND
MCFARLAND, MD, JAMES J	LUZERNE
MCFARLAND, MD, MALCOLM D	PHILADELPHIA
MCGANNON, MD, PATRICK K	YORK
MCGARR, MD, JANET A	ALLEGHENY
MCGARRITY, MD, SUSAN J	LEBANON
MCGARRY, MD, THOMAS E	BUCKS
MCGARVEY, MD, EILEEN F	BUCKS
MCGARVEY, MD, JOSEPH F	BUCKS
MCGARVEY, MD, RICHARD N	ALLEGHENY
MCGAVIC, MD, JOHN S	MONTGOMERY
MCGEADY, MD, STEPHEN J	PHILADELPHIA
MCGEARY, MD, LESTER E	WESTMORELAND
MCGEE, MD, DALE L	ALLEGHENY
MCGEE, MD, DAVID M	ERIE
MCGEE, MD, ELIZABETH L	MONTGOMERY
MCGEE, MD, MICHAEL J	LANCASTER
MCGEE JR, MD, JOSEPH P	DELAWARE
MCGEEHAN, MD, ANN M	STUDENT
MCGEEHAN, MD, JOHN F	LACKAWANNA
MCGEEHAN, MD, JOHN T	CHESTER
MCGEEHAN, MD, PAUL A	ERIE
MCGEORGE, MD, FRANCIS R	ALLEGHENY
MCGETTIGAN, MD, MARIE C	PHILADELPHIA
MCGHEE, MD, JAMES C	CUMBERLAND
MCGILL, MD, CHARLES W	MONTOUR
MCGILL, MD, HERMAN I	PHILADELPHIA
MCGILL, MD, REGINA B	DAUPHIN
MCGILL, MD, RITA L	ALLEGHENY
MCGINLEY, MD, GEORGE W	LEHIGH
MCGINLEY, MD, MARY R	MONTGOMERY
MCGINN, JOHNATHAN D	STUDENT
MCGINNIS, MD, ANDREW W	DELAWARE
MCGINNIS, MD, DAVID E	PHILADELPHIA
MCGINNITY, DO, HARRY D	LYCOMING
MCGLAMERY, MD, MURIEL E	PHILADELPHIA
MCGLAUGHLIN, SHAWN P	STUDENT
MCGLUMPHY, MD, THOMAS H	MONTGOMERY
MCGLYNN, MD, JAMES T	DELAWARE
MCGONIGAL, MD, MICHAEL P	ALLEGHENY
MCGORRIAN, MD, GRACE M	ALLEGHENY
MCGOWAN, KAREN A	STUDENT
MCGOWAN, MD, TRACY A	STUDENT
MCGOWAN, MD, WILLIAM E	DELAWARE
MCGRATH, MD, GLENN A	MONTGOMERY
MCGRATH, MD, JOSEPH M	DAUPHIN
MCGRATH, DO, ROBERT C	WESTMORELAND
MCGRATH, MD, THOMAS J	STUDENT
MCGRATH, DO, WILLIAM J	WESTMORELAND
MCGRAW, MD, THOMAS E	PHILADELPHIA
MCGRAW, DO, THOMAS P J	YORK
MCGRAW JR, MD, JOHN J	BUCKS
MCGREGOR, MD, DEBORAH	PHILADELPHIA
MCGREGOR, MD, ROBERT S	MONTOUR
MCGROGAN, MD, FRANK P	WESTMORELAND
MCGUINN, MD, WILLIAM J	YORK
MCGUIRE, MD, FRANCIS E	BEAVER
MCGUIRE, MD, JAMES J	NORTHAMPTON
MCGUIRE, MD, RICHARD J	CENTRE
MCGUIRE, MD, SEAN P	ALLEGHENY
MCGUIRE, MD, THOMAS E	ERIE
MCHENRY, MD, D J	YORK
MCHENRY, MD, JOHN G	YORK
MCHENRY, MD, THOMAS	ALLEGHENY
MCHUGH, MD, ELMER F	ALLEGHENY
MCHUGH, MD, MARY P	PHILADELPHIA
MCHUGH, MD, REGIS W	WESTMORELAND
MCHUGH, MD, RICHARD D	ALLEGHENY
MCILVAINE, MD, PAUL W	BUCKS
MCINROY, BRIAN D	STUDENT
MCINTYRE, PATRICK E	STUDENT
MCJUNKIN, MD, CHERYL L	ERIE
MCKEATING, MD, JOHN A	ALLEGHENY
MCKEATING, MD, PHILIP J	ALLEGHENY
MCKEE, MD, MICHAEL B	LANCASTER
MCKEE, MD, ROBERT E	BUTLER
MCKEE, MD, RODERICK S	PHILADELPHIA
MCKEE, MD, WAYNE O	SOMERSET
MCKEIGHAN, EXEC DIR, DAVID	DELAWARE
MCKENNA, MD, JAMES P	BEAVER
MCKENNA, KATHLEEN	STUDENT
MCKENNA, MD, MARC W	MONTGOMERY
MCKENNA, MD, PETER J	ALLEGHENY
MCKENNA, MD, SCOT R	STUDENT
MCKENNA, MD, THOMAS J	CAMBRIA
MCKENNA III, DO, JAMES J	LACKAWANNA
MCKENNA JR, MD, ERNEST L	MONTGOMERY
MCKENZIE, MD, HARRY J	STUDENT
MCKENZIE, MD, JAMES G	FRANKLIN
MCKINLEY, MD, DAVID F	MONTOUR
MCKINLEY, MD, DONALD R	CAMBRIA
MCKINLEY, MD, ERIN A	VENANGO
MCKINLEY, MD, RICHARD G	CAMBRIA
MCKINLEY, MD, WAYNE S	JEFFERSON
MCKINLEY, MD, WILLIAM M	CLARION
MCKINNEY, MD, HENRY D	BLAIR
MCKINSTRY, MD, ROBERT B	CHESTER
MCKNIGHT, MD, LANCESS	DELAWARE
MCLAMB, MD, JAMES R	CRAWFORD
MCLANE, MD, ROGERS D	CLEARFIELD
MCLAUCHLAN, GAIL L	STUDENT
MCLAUGHLIN, MD, EDWARD	DELAWARE
MCLAUGHLIN, MD, EDWARD D	PHILADELPHIA
MCLAUGHLIN, MD, FRANK W	LANCASTER
MCLAUGHLIN, MD, GEORGE E	PHILADELPHIA
MCLAUGHLIN, DO, JAMES R	VENANGO
MCLAUGHLIN, MD, JAMES T	ALLEGHENY
MCLAUGHLIN, DO, JOHN P	DAUPHIN
MCLAUGHLIN, MD, RAYMOND S	CHESTER
MCLAUGHLIN, ROBERT H	STUDENT
MCLAUGHLIN, MD, THOMAS W	SCHUYLKILL
MCLAUGHLIN, MD, WILLIAM B	ALLEGHENY
MCLEAN, MD, GORDON K	ALLEGHENY
MCLEAN, MD, JAMES J	BERKS
MCLEAN, MD, THOMAS W	PHILADELPHIA
MCLEER, MD, SUSAN V	PHILADELPHIA
MCLELLAN JR, MD, THOMAS G	FAYETTE
MCLEOD, DO, ALLAN M	PHILADELPHIA
MCLEOD, MD, RODERICK R	ARMSTRONG
MCLIN, MD, LEON N	YORK
MCLOUGHLIN, MD, PATRICK T	BUCKS
MCMAHAN, MD, JOSEPH N	WASHINGTON
MCMAHON, MD, SAMUEL M	NORTHAMPTON
MCMAHON, MD, WILLIAM J	WASHINGTON
MCMAHON JR, MD, JOSEPH F	NORTHAMPTON
MCMASTER, MD, JAMES H	ALLEGHENY
MCMILLAN, MD, DEBORAH M	YORK
MCMILLAN, MD, DONALD L	ALLEGHENY
MCMILLAN, MD, JAMES E	ALLEGHENY
MCMILLAN, MD, WILLIAM S	ALLEGHENY
MCMILLEN, MD, JAMES I	DAUPHIN
MCMONAGLE, MD, CAREY L	FAYETTE
MCMONIGAL, RICHARD S	STUDENT
MCMULLIN, DANA F	STUDENT
MCMURRY, MD, FRED G	MONTOUR
MCNABB, MD, DANIEL M	LACKAWANNA
MCNALL, MD, PEARL G	ALLEGHENY
MCNAMARA, MD, J ARCH	PHILADELPHIA
MCNAMARA, MD, ROBERT M	MONTGOMERY
MCNAMARA, DO, THOMAS W	BEAVER
MCNAMEE SR, MD, WILLIAM B	DELAWARE
MCNAUGHER, MD, WILLIAM M	ALLEGHENY
MCNEAL, MD, SAMUEL W	LANCASTER
MCNEELY, MD, BONNIE L	CAMBRIA
MCNEIL, BRYON K	STUDENT
MCNEIL, MD, PETER E	NORTHUMBRLAND
MCNEIL-JACOBI, MD, ATHOLE G	PHILADELPHIA
MCNEILL, MD, DONALD B	ERIE
MCNELLIS, MD, DONALD R	NORTHAMPTON
MCNETT, MD, DALE L	WARREN
MCNULTY, MD, BARBARA M	ALLEGHENY
MCNULTY, JENNIFER A	STUDENT
MCNULTY, MD, LARRY P	ALLEGHENY
MCNULTY, MD, TIMOTHY P	BEAVER
MCPEAK, MD, VINCENT J	PHILADELPHIA
MCSORLEY, MD, JOHN	ALLEGHENY
MCSORLEY, MD, MARYANN BIDI	PHILADELPHIA
MCTAMMANY, MD, J ROBERT	BERKS
MCVAY, MD, EDWARD J	ALLEGHENY
MCVAY, MD, WILLIAM J	ALLEGHENY
MCWILLIAMS, MD, FRED D	WESTMORELAND
MEADE, MD, ARTURO	PHILADELPHIA
MEADE, MD, THOMAS D	LEHIGH
MEADOWCROFT, MD, JAMES A	MONTGOMERY
MEAKEM, MD, TIMOTHY D	LYCOMING
MEALS, MD, MARGARET	ALLEGHENY
MEARS, DO, CYNTHIA J	DELAWARE
MEARS, MD, DANA C	ALLEGHENY
MEARS, MD, ELMER E	BUCKS
MEARS, SIMON C	STUDENT
MEARS, MD, VIRGINIA G	LANCASTER
MEBANE, MD, TOM S	CENTRE
MEBANE III, MD, TOM S	CENTRE
MEBUS, LISA JANE C	STUDENT
MECCA, MD, DONATO D	LACKAWANNA

MECCA, MD, JOHN J	LEHIGH
MECKLER, MD, MARCIA A	PHILADELPHIA
MECS, MD, SANDOR	ALLEGHENY
MEDDEN, MD, EDWIN J	MCKEAN
MEDIC JR, DO, DANIEL	WESTMORELAND
MEDICH, MD, GEORGE F	BEAVER
MEDINA, MD, RODRIGO D	CARBON
MEDINGER, MD, FRED G	PHILADELPHIA
MEDLOCK, MD, JAMES B	LAWRENCE
MEDWAY, MD, MARC J	MONTGOMERY
MEDWICK, DO, DENISE M M	ALLEGHENY
MEDWICK, DO, GERALD R	ALLEGHENY
MEECE, MD, CHRISTINE A	DAUPHIN
MEEHAN, MD, JOHN J	PHILADELPHIA
MEERAN, MD, M MOHAMED	SCHUYLKILL
MEGALUDIS, MD, ALEXIS M	ALLEGHENY
MEHALICK, DO, PAMELA G	DELAWARE
MEHARG JR, MD, JOHN G	BERKS
MEHDI, MD, IFTIKHAR J	DAUPHIN
MEHOK, MD, RONALD G	ALLEGHENY
MEHROK, HARPAUL S	STUDENT
MEHTA, MD, BHARAT K	NORTHAMPTON
MEHTA, MD, HARSHAD	ALLEGHENY
MEHTA, MD, NIHARIKA D	LUZERNE
MEHTA, MD, PANKAJ	LYCOMING
MEHTA, MD, RAVINDRA K	ALLEGHENY
MEHTA, MD, SUNIL K	MERCER
MEHTA, MD, YOGIN P	MIFFLIN/JUNI
MEHTA, MD, YOGINI R	ALLEGHENY
MEIKLE, MD, CHARLES E	BRADFORD
MEIKLE, MD, GEORGE C	BRADFORD
MEINDL, MD, GEORGE T	WASHINGTON
MEISENHEIMER, HEATHER M	STUDENT
MEISNER, MD, DENNIS J	ALLEGHENY
MEISTER, MD, DONALD G	ALLEGHENY
MELADA, MD, GARY A	ALLEGHENY
MELANI, MD, KENNETH R	ALLEGHENY
MELDRUM, MD, ROBERT W	COLUMBIA
MELICK, MD, JUDITH E	PHILADELPHIA
MELIN, MD, JEFFREY M	PHILADELPHIA
MELLENCAMP, MD, ERIC J	LYCOMING
MELLER, MD, MENACHEM M	MONTGOMERY
MELLER, MD, STEVEN	MONTGOMERY
MELLINGER, MD, RICHARD W	LANCASTER
MELLON, MD, ROBERT	BERKS
MELLON JR, MD, LAWRENCE J	DELAWARE
MELMAN, MD, JAY E	LEHIGH
MELNICK, MD, HOWARD B	LEBANON
MELNICK, MD, JOSEPH L	PHILADELPHIA
MELNICK, MD, SANDY D	PHILADELPHIA
MELOTTI, MICHELLE K	STUDENT
MELOTTI, MD, PETER M	ALLEGHENY
MELOY, MD, THOMAS R	HUNTINGDON
MELTZER, MD, ALAN J	PHILADELPHIA
MELTZER, MD, ARTHUR H	CHESTER
MELTZER, MD, DAVID	MONTGOMERY
MELTZER, MD, MICHELE S	PHILADELPHIA
MELVIN, MD, JOHN L	PHILADELPHIA
MELZER, MD, PATRICIA S	CRAWFORD
MEMEL, MD, DAVID S	ALLEGHENY
MEMON, MD, MOHAMMAD K	WESTMORELAND
MENA, MD, LILIA D	MONTGOMERY
MENACKER, MD, SHERYL J	BUCKS
MENAPACE JR, MD, FRANCIS J	MONTOUR
MENCHEY, MD, MILTON J	YORK
MENCIA, MD, PEDRO R	WAYNE/PIKE
MENDEL, MD, KENNETH D	DELAWARE
MENDEL, MD, RICHARD C	PHILADELPHIA
MENDELL, MD, THEODORE H	PHILADELPHIA
MENDELOW, MD, HARVEY	ALLEGHENY
MENDELSOHN, MD, EUGENE	BERKS
MENDELSON, MD, DAVID J	PHILADELPHIA
MENDELSON, MD, ELLEN B	ALLEGHENY
MENDELSON, MD, MYER	PHILADELPHIA
MENDELSON, MD, S ROBERT	ALLEGHENY
MENDELSSOHN, MD, EDWIN	PHILADELPHIA
MENDELSSOHN, MD, SAUL	LUZERNE
MENDEZ, MD, LEONARDO	PHILADELPHIA
MENDIOLA, ARISTOTLE E	STUDENT
MENDIOLA, MD, CARMELO C	NORTHAMPTON
MENDOZA, MD, ANTONIA A	ALLEGHENY
MENEELY, MD, ALFRED W	DAUPHIN
MENGEL, MD, ROGER G	BERKS
MENGES JR, MD, JOB F	BERKS
MENIN, MD, RICHARD A	PHILADELPHIA
MENIN, MD, WILLIAM	PHILADELPHIA
MENIO, MD, GREGORY J	NORTHAMPTON
MENIO, MD, JOHN N	LUZERNE
MENKOWITZ, MD, ELLIOT	MONTGOMERY
MENNA, MD, VINCENT J	BUCKS
MENNELL, MD, JOHN M	PHILADELPHIA
MENON, MD, ANIL S	ALLEGHENY
MENON, MD, VENU G	PHILADELPHIA
MENON, MD, VIKRAM G	LUZERNE
MENOTIADES, MD, JOHN C	ALLEGHENY
MENSCH, LEON S	STUDENT
MENTYKA, MD, ROBERT A	CENTRE
MENZA, MD, ANTHONY G	MONROE
MENZEL, MD, PAUL H	LACKAWANNA
MENZIES JR, MD, WILLIAM C	MERCER
MERCADO, MD, MODESTO G	LEHIGH
MERCIER, MD, EDWARD E	ERIE
MERCOGLIANO, MD, GIANCARLO	MONTGOMERY
MERCURIO, MD, RICHARD A	ARMSTRONG
MERCURIO, MD, TERESA	BERKS
MERENICH, MD, WILLIAM M	PHILADELPHIA
MERENSTEIN, MD, JOEL H	ALLEGHENY
MERHAV, MD, HADAR J	ALLEGHENY
MERING, MD, THOMAS W	GREENE
MERING JR, MD, JAMES H	ALLEGHENY
MERKE, MD, DEBORAH P	PHILADELPHIA
MERKIN, MD, ALVIN	PHILADELPHIA
MERKLE, MD, LARRY N	LEHIGH
MERLIN, MD, KEITH S	MONTGOMERY
MERLO, DO, FRANCIS A	WAYNE/PIKE
MEROLA, MD, JOSEPH C L	NORTHAMPTON
MEROPOL, MD, NEAL J	PHILADELPHIA
MERRIMAN, MD, W CLAIR	BEAVER
MERSHON, MD, CHARLES R	LANCASTER
MERSKI, MD, ANTHONY T	ERIE
MERSKY, MD, MARTIN R	BUCKS
MERSKY, MD, STEVEN A	PHILADELPHIA
MERSON, MD, ERICH R	CHESTER
MESCHTER, MD, STEVEN C	MONTOUR
MESETE, MD, A FRANCIS	DELAWARE
MESHKOV, MD, ARNOLD B	PHILADELPHIA
MESSINA, DO, MICHAEL P	MERCER
MESSINESE, MD, MARK A	CAMBRIA
MESSMER, MD, JOHN J	LEBANON
MESSNER, MD, JEAN T	DAUPHIN
MESSNER, MD, KENNETH H	LANCASTER
MESSORI, MD, DIVO A	PHILADELPHIA
META, MD, LOUIS D	ALLEGHENY
METCALFE, MD, MARC F	ALLEGHENY
METHRATTA, MD, SOSAMMA T	PHILADELPHIA
METKUS, MD, FRANCIS M	BUCKS
METRO JR, DAVID G	STUDENT
METZ, MD, WALTER A R	ALLEGHENY
METZGER, MD, PAUL C	LACKAWANNA
MEUSBURGER, MD, CHARLES E	PHILADELPHIA
MEYER, MD, ALLEN E	DELAWARE
MEYER, DANIEL K	STUDENT
MEYER, MD, DAVID G	WESTMORELAND
MEYER, MD, KATHRYN J	PHILADELPHIA
MEYERS, MD, FREDERIC A	CHESTER
MEYERS, MD, JOHN L	BERKS
MEYERS, MD, KARL R	PHILADELPHIA
MEYERS, MD, PAUL T	CAMBRIA
MEYERS, MD, ROBERT W	PHILADELPHIA
MEYERSON, MD, ARTHUR T	PHILADELPHIA
MEZEY, MD, ALAN L	PHILADELPHIA
MEZZANOTTE, MD, JOHN J	PHILADELPHIA
MIAN, JAMSHID S	STUDENT
MIANO, MD, LIDIA	BEAVER
MIASKIEWICZ, MD, STASIA L	ALLEGHENY
MICAILY, MD, BIZHAN	PHILADELPHIA
MICHAEL, MD, ANDREW J	PHILADELPHIA
MICHAEL, MD, DWIGHT I	ADAMS
MICHAEL, MD, GARY E	LEHIGH
MICHAEL, MD, JOSEPH T	ALLEGHENY
MICHAELS, MD, BERNARD I	ALLEGHENY
MICHAELS, MD, MIKE	DELAWARE
MICHAELS, MD, MILTON M	ALLEGHENY
MICHAELS, MD, ROBERT M	BRADFORD
MICHAELSON, MD, CAROLYN Z	PHILADELPHIA
MICHAELSON, MD, JANET M	MONTGOMERY
MICHAELSON, MD, THOMAS C	CHESTER
MICHALAK, MD, DENNIS M W	BRADFORD
MICHALAK, MD, WILLIAM A	LUZERNE
MICHALEK, MD, MARIA	DAUPHIN
MICHALOPOULOS, MD, GEORGE K	ALLEGHENY
MICHALS, MD, TIMOTHY J	PHILADELPHIA
MICHAUD, MD, JOSEPH E	CAMBRIA
MICHEEL-MARRIE, MD, STACIE A	STUDENT
MICHEL, MD, ELLIOT M	ALLEGHENY
MICHEL, MD, JOHN P	BEAVER
MICHELSTEIN, MD, RICHARD D	LUZERNE
MICHIE, MD, ALEXANDER J	MONROE
MICKLER, MD, THOMAS A	PHILADELPHIA
MIDDLEMAN, MD, ROSE R	ALLEGHENY
MIDDLETON, MD, DONALD B	ALLEGHENY
MIDDLETON, MD, ROBERT J	COLUMBIA
MIDMORE, MD, JOHN S	LYCOMING
MIELCAREK JR, MD, LEON M	DELAWARE
MIELE, MD, GERALD B	LUZERNE
MIGLIORE, MD, JOSEPH J	LYCOMING
MIGNOTT, MD, HAROLD L	PHILADELPHIA
MIHELIC, MD, NICHOLAS E	HUNTINGDON
MIHU, MD, ROXANA G	PHILADELPHIA
MIKAELIAN, MD, DIRAN O	PHILADELPHIA
MIKAYA, MD, MARTIN L	BRADFORD
MIKE, MD, MARGARET E	PHILADELPHIA
MIKE-MAYER, MD, HENRIK	BLAIR
MIKELBERG, MD, ROSE R	PHILADELPHIA
MIKELONIS, MD, ROBERT J	CENTRE
MIKESELL, MD, JERRY F	CENTRE
MIKETIC, MD, LINDA M	ALLEGHENY
MIKITA, MD, JOHN J	ALLEGHENY
MIKLOS, MD, BERNARD G	ALLEGHENY
MIKLOS, MD, JOHN R	PHILADELPHIA
MIKNEVICH, MD, MARYANN	ALLEGHENY
MIKOWSKI, MD, I EDMUND	PHILADELPHIA
MIKULLA, MD, JOHN M	ALLEGHENY
MIKUTA, MD, JOHN J	PHILADELPHIA
MILAI JR, MD, AHMED S	ALLEGHENY
MILANI, MD, FRANK A	LACKAWANNA
MILAZZO, MD, JOHN V	BUCKS
MILCHAK, MD, MARK A	BEAVER
MILDENBERG, MD, BUDD J	MONTGOMERY
MILES, DO, G BRUCE	NORTHAMPTON
MILEWSKI, MD, LEONARD F	DELAWARE
MILGRAM, MD, KENNETH K	WARREN
MILICH, MD, ZARKO D	MONROE
MILICIA, MD, ANTHONY P	PHILADELPHIA
MILKE, MD, DENIS J	DAUPHIN
MILKS, MD, CARL J	WAYNE/PIKE
MILLER, MD, ALAN M	MONTGOMERY
MILLER, MD, ALLEN C	PHILADELPHIA
MILLER, MD, ANN C	MONTGOMERY
MILLER, MD, BRIAN A	BUCKS
MILLER, MD, C EUGENE	LANCASTER
MILLER, MD, C JOSEPH	PHILADELPHIA
MILLER, MD, CARL S	LEBANON
MILLER, MD, CHARLES F	CHESTER
MILLER, MD, CLAUDE J	LEBANON
MILLER, MD, CURT D	DELAWARE
MILLER, MD, CYNTHIA L	PHILADELPHIA
MILLER, MD, D SCOTT	ALLEGHENY
MILLER, MD, DAVID	PHILADELPHIA
MILLER, MD, DAVID H	BUCKS
MILLER, DO, DAVID J	BUCKS
MILLER, MD, DAVID L	CLARION
MILLER, MD, DAVID L	ALLEGHENY
MILLER, MD, DAVID M	ALLEGHENY
MILLER, DAVID R	STUDENT
MILLER, MD, DAVID S	PHILADELPHIA
MILLER, MD, DAVID S	HUNTINGDON
MILLER, MD, DONALD S	MONTGOMERY
MILLER, MD, DOREEN E	LEBANON
MILLER, MD, EARL R	LYCOMING
MILLER, MD, EDWARD B	ALLEGHENY
MILLER, MD, EDWARD J	CARBON
MILLER, MD, FRANCINE J	PHILADELPHIA
MILLER, MD, FRANK L	MONTGOMERY
MILLER, MD, FREDERICK A	ALLEGHENY
MILLER, MD, G GEOFFREY	LUZERNE
MILLER, MD, GERALD E	LANCASTER
MILLER, MD, GLADYS M	PHILADELPHIA
MILLER, MD, GLENN D	PHILADELPHIA
MILLER, MD, HARRY I	ALLEGHENY
MILLER, HELENE ANNE	STUDENT
MILLER, MD, HERBERT D	ALLEGHENY
MILLER, MD, HERMAN	DELAWARE
MILLER, MD, HOWARD A	PHILADELPHIA
MILLER, MD, HOWARD J	POTTER
MILLER, DO, JAMES C	DAUPHIN
MILLER, MD, JAMES M	SUSQUEHANNA
MILLER, MD, JAMES R	YORK
MILLER, MD, JAY B	BERKS
MILLER, DO, JEFFREY A	DELAWARE
MILLER, JEFFREY J	STUDENT
MILLER, MD, JEFFREY L	PHILADELPHIA
MILLER, DO, JERI L	PHILADELPHIA
MILLER, MD, JEROME	PHILADELPHIA
MILLER, DO, JEROME	PHILADELPHIA
MILLER, MD, JOHN L	MERCER
MILLER, MD, JOSEPH A	LEHIGH
MILLER, MD, JOSEPH J	FRANKLIN
MILLER, MD, KERRY D	LEHIGH
MILLER, MD, LAWRENCE S	DELAWARE
MILLER, MD, LEE C	DAUPHIN
MILLER, MD, LEE H	BUCKS
MILLER, MD, LEONARD D	PHILADELPHIA
MILLER, DO, LOIS M	MONTOUR
MILLER, MD, MARK A	PHILADELPHIA
MILLER, MD, MARK A	ALLEGHENY
MILLER, MD, MICHAEL B	BUCKS
MILLER, MD, MICHAEL D	ALLEGHENY
MILLER, MD, MORRIS	PHILADELPHIA
MILLER, MD, MYRON D	LEBANON
MILLER, PAMELA M	STUDENT
MILLER, MD, PARRY J	LANCASTER
MILLER, MD, PAUL K	CUMBERLAND
MILLER, MD, RALPH J	ALLEGHENY
MILLER, MD, RALPH J	INDIANA
MILLER, MD, RICHARD E	SCHUYLKILL
MILLER, MD, ROLAND E	ERIE
MILLER, MD, STANTON B	PHILADELPHIA
MILLER, MD, STEPHEN J	ALLEGHENY
MILLER, MD, SUSAN A	VENANGO
MILLER, MD, THOMAS J	MONTGOMERY
MILLER, MD, THOMAS L	LANCASTER
MILLER, MD, WAYNE R	NORTHUMBERLAND
MILLER, MD, WILLIAM B	ALLEGHENY
MILLER, MD, WILLIAM H	ALLEGHENY
MILLER, MD, WILLIAM J	ALLEGHENY
MILLER II, MD, GEORGE C	UNION
MILLER II, MD, TOM R	ERIE
MILLER III, MD, O FRED	MONTOUR
MILLER JR, MD, CLARENCE M	ALLEGHENY
MILLER JR, MD, JOHN W	LANCASTER
MILLER JR, MD, WILLIAM B	DAUPHIN
MILLER-SCHAEFFER, MD, CAROL A	SCHUYLKILL
MILLIGAN, MD, ROBERT S	ALLEGHENY
MILLINER, MD, DAVID H	DELAWARE
MILLMAN, DARLENE W	STUDENT
MILLMOND, MD, STEVEN H	PHILADELPHIA
MILLS, MD, JOHN W	INDIANA
MILLS, MD, M DUANE	DAUPHIN
MILLS, STEVEN E	STUDENT
MILLS, MD, WILLIAM L	BUCKS
MILLS, EXEC SEC, CAROLINE	BEAVER
MILLSTEIN, MD, JEFFREY H	PHILADELPHIA
MILLWARD JR, CARL L	STUDENT
MILNER, ROSS	STUDENT
MILON, MD, CHARLES F	PHILADELPHIA
MILORO, MD, MICHAEL J	PHILADELPHIA
MILROTH, MD, WILLIAM L	FRANKLIN
MILSTEEN, MD, SCOTT A	DAUPHIN
MILSTEIN, MD, HAROLD J	LUZERNE
MILSTEIN, MD, SEYMOUR W	DELAWARE
MIN, MD, JUNG T	BEAVER
MIN, MD, TAE C	BEAVER
MINARD, MD, WILLIAM D	MONTGOMERY
MINCZAK, BOHDAN M	STUDENT
MINDRUM, MD, GERALD G	FRANKLIN
MINEHART, MD, CHARLES R	BERKS
MINEHART, MD, JOHN R	PHILADELPHIA
MINELLA, MD, RICCI A	ALLEGHENY
MINERVA, MD, FELICISIMA B	PHILADELPHIA
MINES, MD, SAMUEL C	ALLEGHENY
MINGEY, MD, DEBORAH L	ERIE
MINGRONI, DO, JULIUS A	PHILADELPHIA
MINHAS, MD, TASEER A	ALLEGHENY
MINION, MD, STEVEN L	PHILADELPHIA
MINISSALE, DO, JOSEPH J	PHILADELPHIA
MINK, MD, KENNETH R	STUDENT
MINN, MD, FREDRICK L	MONTGOMERY
MINNICH, MD, KEITH A	BERKS
MINNICH, MD, MARIE E	MONTOUR
MINNICH, MD, PHILIP H	YORK
MINNICH, MD, STEPHEN J	MONTOUR
MINNO, MD, ALEXANDER M	ALLEGHENY
MINO, MD, DAVID E	BUCKS
MINO, MD, ROBERT D	MONTGOMERY
MINOR, MD, MARK R	HUNTINGDON
MINORA, MD, MICHAEL A	LACKAWANNA
MINORA, MD, THOMAS L	LACKAWANNA
MINTEER, MD, JEFFREY F	WASHINGTON
MINTEER JR, DO, DONALD W	ARMSTRONG
MINTON, MD, MICHAEL D	ALLEGHENY
MINTON, MD, RUSSELL F	PHILADELPHIA
MINTZ, MD, PAUL S	BERKS
MINTZ, PHILIP S	STUDENT
MINTZER, MD, DAVID M	PHILADELPHIA
MINTZER, DO, HARRY D	LYCOMING
MIR, MD, DAVID J	ERIE
MIR, MD, TAHIR U	INDIANA
MIRA, MD, ALLAN J	CUMBERLAND
MIRABILE, MD, ROBERT J	MONTGOMERY
MIRAGLIA, MD, RICHARD J	MONROE
MIRANDA, MD, AURORA M	ALLEGHENY
MIRARCHI, MD, VINCENZO	NORTHMBRLAND
MIRCHANDANI, MD, HARESH G	PHILADELPHIA
MIRRO, MD, BETTY J	ALLEGHENY
MIRSKY, MD, HOWARD A	YORK
MIRSKY, MD, ROBERT S	BUCKS
MIRTH-JACOBELLI, DO, BARBARA L	BUCKS
MIRZA, MD, MOHAMMAD R	LYCOMING
MIRZABEIGI, MD, NEMATOLLAH	ALLEGHENY
MISAGE, MD, JOHN R	ALLEGHENY
MISCHLER, MD, FORREST C	ERIE
MISENHIMER, MD, MARTIN D	LEHIGH
MISHALOVE, MD, R DAVID	DELAWARE
MISHEL, MD, HENRY S	MONTGOMERY
MISHER-HARRIS, DO, MICHELE I	DELAWARE
MISHKIN, MD, MARK H	LEHIGH
MISHKIN, MD, MARK M	PHILADELPHIA
MISHRA, MD, RANDHIR	CLINTON
MISRA, MD, HARI K	WESTMORELAND
MISTRY, MD, MEHERWAN J	WAYNE/PIKE
MITAL, MD, MOHAN S	CAMBRIA
MITAL, MD, NIRMAL G	CAMBRIA
MITCHELL, MD, ARTHUR B	LUZERNE
MITCHELL, MD, DAVID R	ALLEGHENY
MITCHELL, ELIZABETH A	STUDENT
MITCHELL, MD, ELIZABETH M	MONTGOMERY
MITCHELL, MD, FENTON M	ALLEGHENY
MITCHELL, MD, HAROLD L	ALLEGHENY
MITCHELL, MD, HENRY	INDIANA
MITCHELL, MD, JOHN F	LEHIGH
MITCHELL, MD, ROBERT M	PHILADELPHIA
MITCHELL, MD, WILLIAM J	FAYETTE
MITNICK, MD, PAUL D	BERKS
MITRA, MD, ATIN K	ERIE
MITRE, MD, BLIMA K	ALLEGHENY
MITRE, MD, RICARDO J	ALLEGHENY
MITRO, DO, ROBERT N	ALLEGHENY
MITRO, MD, WILLIAM	ALLEGHENY
MITROS, MD, MARK M	ALLEGHENY
MITTAL, MD, BABANT K	NORTHMBRLAND
MITTAL, MD, SUNEET	PHILADELPHIA
MITTELDORF, MD, STEPHEN E	PHILADELPHIA
MITTELL, MD, DAVID C	WASHINGTON
MITTICA, MD, NICHOLAS M	LAWRENCE
MITTMAN, MD, DEAN	LACKAWANNA
MITZEL, DO, TIMOTHY S	ALLEGHENY
MIURA, MD, KAREN K	PHILADELPHIA
MIX, MD, WILLIAM A	ERIE
MIYAMOTO, MD, CURTIS T	DELAWARE
MIZIN, MD, LAKSHMI D J	LACKAWANNA
MLECKO, MD, LAWRENCE M	ALLEGHENY
MLINAR, LAURA S	STUDENT
MOATS, MD, ANTHONY W	ALLEGHENY
MOBERG, MD, F BARRIE	LANCASTER
MOCH, ANNE L	STUDENT
MOCK, MD, GREGORY D	CAMBRIA
MOCLOCK, MD, MICHAEL A	LUZERNE
MODARRESS, MD, JOHN Y	SCHUYLKILL
MODERY, MD, MARSHA E	ALLEGHENY
MODESTO, MD, THOMAS A	MONTOUR
MODI, MD, JASHWANT B	ALLEGHENY
MODY, MD, MAHENDRA I	BUCKS
MOERKIRK, MD, GEORGE E	LEHIGH
MOFFA, MICHAEL A	STUDENT
MOFFITT, MD, VINCENT J	BERKS
MOFFITT JR, MD, GEORGE R	DAUPHIN
MOFFSES, MD, GARABED H	PHILADELPHIA
MOGERMAN, MD, JEFFREY A	LACKAWANNA
MOGERMAN, MD, RICHARD L	LACKAWANNA
MOGHADAM, MD, ABDOL NABI	PHILADELPHIA
MOGHADAM, MD, EILEEN S	PHILADELPHIA
MOGIL, MD, ROBERT A	PHILADELPHIA
MOGUL, MD, ROBERT	BUCKS
MOHAMADI, MICHELE S	STUDENT
MOHAMED-ALI, MD, ABUL-KASSIM	LACKAWANNA
MOHAN, MD, BRIJ	NORTHAMPTON
MOHAN, MD, FRANCIS P	SCHUYLKILL
MOHAN, MD, KRISHNA K	PHILADELPHIA
MOHEIMANI, CHRISTOPHER H	STUDENT

MOHIUDDIN, MD, MOHAMMED	PHILADELPHIA
MOHIUDDIN, MD, MOHAMMED A	PHILADELPHIA
MOHLER, MD, J HAROLD	LANCASTER
MOHR, MD, ROSE M	PHILADELPHIA
MOHYUDDIN, MD, MOIZ	MONROE
MOIDEL, MD, ROBERT A	MONTGOMERY
MOISE, MD, ADRIANA G	PHILADELPHIA
MOKRYNSKI, MD, GREG	PHILADELPHIA
MOKYCHIC, MD, WALTER E	LUZERNE
MOLDOFSKY, MD, PHILIP J	PHILADELPHIA
MOLESKI, MD, DESMOND D	WARREN
MOLINDA, MD, LAURIE S	ALLEGHENY
MOLL, MD, ALISON	YORK
MOLL, MD, DAVID C	BUCKS
MOLL, MD, GEORGE A	PHILADELPHIA
MOLL, MD, THOMAS B	BERKS
MOLLICK, MD, JAMES A	MONTGOMERY
MOLLICK, MD, JAMES L	MONTGOMERY
MOLLOY, MD, PETER J	ALLEGHENY
MOLLURA, MD, JOSEPH A	ALLEGHENY
MOLONEY, MD, JOSEPH D	DAUPHIN
MOMAN JR, MD, LAWRENCE C	ALLEGHENY
MOMIN, MD, MALIK N	DAUPHIN
MONAHAN, FRANCINE M	STUDENT
MONAHAN, MD, GEORGE R	MONTGOMERY
MONAHAN, MD, MARYELLEN R O	LACKAWANNA
MONARDO, MD, ALFRED	ALLEGHENY
MONASTERIO, MD, JOSE R	CHESTER
MONCMAN, DO, MICHAEL-GERARD	BLAIR
MONDALA-OCBO, MD, ELISA V	BERKS
MONDEREWICZ, KATHLEEN M	STUDENT
MONDERO, DO, NANCY A	LANCASTER
MONDZELEWSKI, MD, JAMES P	ALLEGHENY
MONG, MD, KAM W	YORK
MONGIA, SUMEDHA	STUDENT
MONGIARDO, JAY P	STUDENT
MONHEIT, MD, RICHARD S	PHILADELPHIA
MONITTO, MD, CONSTANCE L	PHILADELPHIA
MONK, MD, JOHN S	YORK
MONK JR, MD, JOHN S	YORK
MONKOWSKI, MD, ALFRED M	BUCKS
MONSAERT, MD, RONALD P	MONTOUR
MONSOUR, MD, GEOFFREY B	WESTMORELAND
MONSOUR, MD, ROBERT G	WESTMORELAND
MONSOUR, MD, ROY C	WESTMORELAND
MONSOUR, MD, ROY C	WESTMORELAND
MONSOUR, MD, ROY E	ADAMS
MONSOUR, MD, WILLIAM J	WESTMORELAND
MONTAG, MARK C	STUDENT
MONTAGUE, MD, JAMES W	LYCOMING
MONTALBO, MD, ANTONIO A	CENTRE
MONTALBO, MD, SERAFIN A	WESTMORELAND
MONTANER, MD, CARMEN G	LEHIGH
MONTANER, MD, JOSE L	DAUPHIN
MONTE, MD, D MARIE	CHESTER
MONTECALVO, MD, RAYMOND M	PHILADELPHIA
MONTEFORTE, MD, JOSEPH S	PHILADELPHIA
MONTEFORTE, MARK J	STUDENT
MONTEIRO, MD, DENNIS T	PHILADELPHIA
MONTELEONE, MD, PAUL N	CAMBRIA
MONTELLA, MD, DIANE L	LEHIGH
MONTELLA, MD, MICHAEL	LACKAWANNA
MONTELLO, MD, JOAN M	CUMBERLAND
MONTES, MD, MANUEL Y	CARBON
MONTEBANO, MD, ANGELICA T	PHILADELPHIA
MONTGOMERY, MD, BRUCE B	CUMBERLAND
MONTGOMERY, MD, ERNEST J	ARMSTRONG
MONTGOMERY, MD, HUGH	PHILADELPHIA
MONTGOMERY, MD, KARLA J	PHILADELPHIA
MONTGOMERY, MD, LYNN C	PHILADELPHIA
MONTGOMERY, MD, MARK R	FAYETTE
MONTGOMERY, MD, OWEN C	PHILADELPHIA
MONTGOMERY, MD, PATRICIA A	DELAWARE
MONTGOMERY, MD, THADDEUS L	PHILADELPHIA
MONTGOMERY JR, MD, GEORGE A	SOMERSET
MONTOURIS, MD, ELAINE A	ALLEGHENY
MONTZKA, MD, DAN P	DELAWARE
MONYAK, MD, JOHN G	BEAVER
MONYAK, MD, SANDRA G	ALLEGHENY
MOODY, MD, JACK H	DAUPHIN
MOODY, MD, ROBERT A	BRADFORD
MOON, BRIAN W	STUDENT
MOON, MD, HENRY S	WASHINGTON
MOON, MD, SUNG B	WESTMORELAND
MOONDA, MD, GULAMHUSAIN	MERCER
MOONEY, MD, BENJAMIN R	YORK
MOONEY, MD, WILLIAM E	ALLEGHENY
MOORE, MD, BARRY S	DAUPHIN
MOORE, MD, BRAD S	PHILADELPHIA
MOORE, MD, CHARLES A	GREENE
MOORE, MD, DANIEL W	BUCKS
MOORE, MD, DAVID H	YORK
MOORE, MD, DAVID H	LUZERNE
MOORE, MD, DAVID S	LUZERNE
MOORE, ELIZABETH A	STUDENT
MOORE, ERIC J	STUDENT
MOORE, MD, ERNEST E	BUTLER
MOORE, MD, GEORGE W	LAWRENCE
MOORE, MD, JAMES P	ARMSTRONG
MOORE, MD, JAY R	PHILADELPHIA
MOORE, MD, JOSEPH J	TIOGA
MOORE, MD, LEROY C	ALLEGHENY
MOORE, MD, LUANA R C	PHILADELPHIA
MOORE, MD, MATTHEW T	PHILADELPHIA
MOORE, MD, MICHAEL F	LACKAWANNA
MOORE, MD, RICHARD A	CAMBRIA
MOORE, MD, RICHARD S	PHILADELPHIA
MOORE, MD, TERENCE E	ARMSTRONG
MOORE, MD, TERENCE N	LANCASTER
MOORE, MD, TIMOTHY D	ALLEGHENY
MOORE, DO, WILLIAM D	BUCKS
MOORE JR, MD, JOHN H	PHILADELPHIA
MOORE JR, MD, SAMUEL R	PHILADELPHIA
MOORE SR, MD, ROBERT G	LANCASTER
MOOREVILLE, MD, MICHAEL	DELAWARE
MOORTHY, MD, GITA	YORK
MOOSSY, MD, JOHN J	ALLEGHENY
MORACA, MD, JOHN I	ALLEGHENY
MORAITIS, MD, CONSTANTINE Z	ALLEGHENY
MORALE, MD, SAMUEL G	PHILADELPHIA
MORALES, MD, AUGUSTIN F M P	BERKS
MORALES, MD, DIEGO	PHILADELPHIA
MORALES, MD, FRANCISCO J	LEBANON
MORALES, MD, GLADYS D	NORTHAMPTON
MORALES-PELAEZ, MD, EILEEN S	PHILADELPHIA
MORAN, MD, JOHN J	MONTOUR
MORAN, DO, MARK E	LEHIGH
MORAN JR, MD, THOMAS W	WESTMORELAND
MORANDI, NEIL P	STUDENT
MORANI, MD, ALMA D	PHILADELPHIA
MORANZ, MD, JOEL G	DELAWARE
MORASCO, MD, EDWARD R	LEBANON
MORE, KENNETH F	STUDENT
MORENO, HERMANN A	STUDENT
MORENO, MD, MANUEL V	LYCOMING
MORESCHI, LISA M	STUDENT
MORESEA, GEORGE A	STUDENT
MORETTO, MD, JOSEPH L	LAWRENCE
MORFFI, MD, OSCAR A	LEHIGH
MORGAN, MD, ALLAN V	ALLEGHENY
MORGAN, MD, CORINNE M	MONTGOMERY
MORGAN, MD, JAMES J	MIFFLIN/JUNI
MORGAN, MD, JEFFREY F	WARREN
MORGAN, MD, JOHN M	DELAWARE
MORGAN, MD, RUSSELL E	NORTHAMPTON
MORGAN, MD, VINCENT F	BLAIR
MORGAN, MD, WILLIAM F	NORTHAMPTON
MORGAN, MD, YVONNE G	BERKS
MORGAN JR, MD, JAMES W	UNION
MORGAN JR, MD, VERNON W	LACKAWANNA
MORGAN-IHRIG, MD, CHERYL L	ALLEGHENY
MORGANROTH, MD, JOEL	PHILADELPHIA
MORGART, MD, DOUGLAS R	LUZERNE
MORGENSTERN, MD, DIANA M	PHILADELPHIA
MORGENSTERN, KENNETH E	STUDENT
MORGENSTERN, MD, STEPHEN A	MONTGOMERY
MORI, MD, GINO	LACKAWANNA
MORI, MD, HUGO	LACKAWANNA
MORIARTY, MD, RICHARD W	ALLEGHENY
MORINIGO-MESTRE, MD, BLANYS	PHILADELPHIA
MORITZ, MD, MICHAEL J	YORK
MORITZ, MD, MORDEKHAI	LACKAWANNA
MORK, MD, GUSTAVE W	ERIE
MORLEY, MD, ROBERT R	DELAWARE
MORREELS JR, MD, CHARLES L	YORK
MORRELL, DO, ROGER W	CAMBRIA
MORRIS, MD, ADRIAN J	LACKAWANNA
MORRIS, MD, DENNIS L	LEHIGH
MORRIS, MD, ELEANOR G	SOMERSET
MORRIS, JAMIE L	STUDENT
MORRIS, MD, JON S	PHILADELPHIA
MORRIS, MD, LESLIE E	ALLEGHENY
MORRIS, DO, MATILDA J	MERCER
MORRIS, MD, MICHAEL C	PHILADELPHIA
MORRIS, MD, PATRICIA A	NORTHAMPTON
MORRIS, MD, RICHARD J	DELAWARE
MORRIS, MD, ROBERT S	MONTGOMERY
MORRIS, MD, SHELDON L	DELAWARE
MORRIS JR, MD, JAMES A	DELAWARE
MORRIS JR, MD, ROBERT G	WYOMING
MORRIS JR, MD, VERNON R	BERKS
MORRIS JR, DO, WILSON S	LEBANON
MORRISON, ALAN L	STUDENT
MORRISON, MD, ALAN N	LEHIGH
MORRISON, MD, BRUCE W	ALLEGHENY
MORRISON, MD, KEVIN S	YORK
MORRISON, MD, MARJORIE G	LEHIGH
MORRISON, MD, SAMUEL S	MONTOUR
MORRISON SR, MD, JOSEPH F	LUZERNE
MORRISSEY, MD, WILLIAM L	PHILADELPHIA
MORRISSEY JR, MD, E JAMES	BERKS
MORRONE, DO, CHARLES C	PHILADELPHIA
MORROW, MD, BERT A	BERKS
MORROW, MD, CHARLES A	TIOGA
MORROW, MD, HERBERT J	WESTMORELAND
MORROW, MD, ROBERT A	LEHIGH
MORROW, MD, ROBERT E	MONROE
MORROW, MD, THAYER K	WESTMORELAND
MORSE, JOSEPH D	STUDENT
MORSE, MD, RICHARD J	BERKS
MORTEL, MD, RODRIGUEZ	DAUPHIN
MORTIMER, MD, GREGORY P	ALLEGHENY
MORTON, MD, JOHN C	DAUPHIN
MORTON, MD, MARGARET S	ALLEGHENY
MORTON, MD, ROBERT J	WAYNE/PIKE
MOSCA, MD, KATHARINE S	ALLEGHENY
MOSCATO, MD, ANTHONY F	NORTHAMPTON
MOSCH, MD, GEORGE C	POTTER
MOSCH, MD, HERMAN C	POTTER
MOSER, MD, EDWARD N	LYCOMING
MOSER, MD, JOHN C	BERKS
MOSES, MD, JAMES M	CAMBRIA
MOSES, MD, MELVIN L	PHILADELPHIA
MOSKAL, MD, JOSEPH P	PHILADELPHIA
MOSKEL, MD, PETER	LACKAWANNA
MOSKOVITZ, MD, MORRY	BEAVER
MOSKOWITZ, MD, BARRY D	ALLEGHENY
MOSS, DAVID A	STUDENT
MOSS, MD, EDWARD R	PHILADELPHIA
MOSS JR, MD, VASSAR Y	ALLEGHENY
MOST-LEVIN, MD, CAROL	MONTGOMERY
MOSTER, MD, MARLENE R	PHILADELPHIA
MOSTOUFIZADEH, MD, MAHPAREH	ALLEGHENY
MOTLEY, DARLENE M	STUDENT
MOTLEY, MD, JOHN F	MONTGOMERY
MOTRONI, MD, ALEXSANDRA K	LEHIGH
MOUFARREJ, MD, MIRNA E	BERKS
MOULTON, MD, MICHAEL P	PHILADELPHIA
MOURADIAN, ROBERT D	STUDENT
MOURY JR, MD, NELSON F	MONTGOMERY
MOUTSOS, MD, SPERO E	CRAWFORD
MOWAD, MD, CHRISTEN M	PHILADELPHIA
MOWAD, MD, JOSEPH J	MONTOUR
MOWERY, DAVID C	STUDENT
MOXEN, MD, JOHN M	LACKAWANNA
MOY, MD, KAI H	BERKS
MOYER, MD, DENNIS L	BUCKS
MOYER, MD, EARL S	DAUPHIN
MOYER, MD, GLENN E	NORTHAMPTON
MOYER, MD, JAMES E	MONROE
MOYER, MD, JOHN F	ALLEGHENY
MOYER, MD, JOHN H	DAUPHIN
MOYER, MD, JOHN P	BUCKS
MOYER, MD, PAUL R	BUCKS
MOYER, MD, RAY A	PHILADELPHIA
MOYER, MD, THELBERT R	ERIE
MOYER JR, MD, ROBERT D	STUDENT
MOYERS, MD, ROBERT N	CRAWFORD
MOYLAN, MD, JOSEPH E	LACKAWANNA
MOZLEY JR, MD, P DAVID	PHILADELPHIA
MRAZ, MD, JAMES E	ERIE
MRAZ, MD, JOHN P	ERIE
MRKICH, MD, ROBERT	CAMBRIA
MRUK, MD, CELESTE C	MONTGOMERY
MRVOS, MD, DIANA L	ALLEGHENY
MRVOS, MD, DONALD M	ALLEGHENY
MSZANOWSKI, MD, EDWIN M	ERIE
MUALLEM, MD, NABIL S	BERKS
MUCCIO, MD, DANIEL J	WESTMORELAND
MUCH, DO, MANDELL J	DELAWARE
MUCHA, MD, STEPHEN J	MONTGOMERY
MUCHLADO, MD, FELIX J	ALLEGHENY
MUDGE, MD, KIMBERLEE	YORK
MUDRICK, MD, DAVID L	DELAWARE
MUELLER, MD, HENRY M	MERCER
MUETTERTIES, MD, CRAIG L	DELAWARE
MUFSON, MD, RICHARD A	BUCKS
MUHLENBERG, MD, J PETER	BERKS
MUHLFELDER, MD, WARREN J	BLAIR
MUHONEN, D, OLIVER A	ALLEGHENY
MUIR, J GAVIN A	STUDENT
MUKHERJEE, MD, SHANKER	NORTHAMPTON
MULHATTEN, MD, DONALD E	CENTRE
MULHERN, MD, LAWRENCE M	ALLEGHENY
MULHOLLAND, MD, S GRANT	PHILADELPHIA
MULKERIN, DANIEL L	STUDENT
MULL, MD, JOSEPH C	WARREN
MULL, MD, THOMAS D	MONTGOMERY
MULLEN, MD, EDWARD E	ALLEGHENY
MULLEN, MD, JAMES L	PHILADELPHIA
MULLEN, MD, MARK J	PHILADELPHIA
MULLER, MD, ALFONS J	PHILADELPHIA
MULLER, DO, ARTHUR J	DAUPHIN
MULLER, MD, GARY W	PHILADELPHIA
MULLER, MD, H ARNOLD	LEBANON
MULLER, MD, OTTO F	DELAWARE
MULLICK, MD, JOWHERI J	VENANGO
MULLICK, MD, PRABIR K	ALLEGHENY
MULLIGAN, MD, JAMES F	YORK
MULLIGAN, MD, ROBERT L	BERKS
MULLIN JR, MD, EDWARD M	LEHIGH
MULLIN JR, MD, HUGH J	BUCKS
MULUKUTLA, MD, RAJYALAKSHMI	PHILADELPHIA
MUMBAUER, STEVEN W	STUDENT
MUNCHAK JR, MD, JOHN	LEHIGH
MUNDTH, MD, ELDRED D	DELAWARE
MUNGUL, MD, USE M	PHILADELPHIA
MUNIR, MD, MOHAMMAD M	NORTHUMBERLAND
MUNIR, MD, MUHAMMAD	SCHUYLKILL
MUNLEY, MD, BRIAN J	BUCKS
MUNSHOWER, DO, THOMAS E	DELAWARE
MUNSON, MD, FREDERICK J	NORTHAMPTON
MUNTHER, MD, ANTOINE S	ERIE
MUNVES, MD, JONATHAN H	NORTHAMPTON
MUNZER, MD, STEVEN J	PHILADELPHIA
MUNZO, MD, MELISSA M	PHILADELPHIA
MURCEK, MD, MARTIN A	WESTMORELAND
MURDOCK, MD, FRED E	JEFFERSON
MURDOCK, MD, MORTON G	PHILADELPHIA
MUREEBE, MD, LEILA	STUDENT
MURELLO, MD, DAVID M	FAYETTE
MURILLO, MD, OSCAR	NORTHAMPTON
MUROFF, DO, ROBERT E	DELAWARE
MURPHEY, MD, SHEILA A	PHILADELPHIA
MURPHEY, MD, STEPHEN M	ALLEGHENY
MURPHY, ANDREW W	STUDENT
MURPHY, MD, BARBARA J	DELAWARE
MURPHY, BRIAN J	STUDENT
MURPHY, MD, BRIAN P	LEHIGH
MURPHY, MD, EDITH L	LYCOMING
MURPHY, EDWARD	STUDENT
MURPHY, MD, J THOMAS	MONTGOMERY
MURPHY, MD, JOHN B	PHILADELPHIA
MURPHY, DO, PATRICK	DELAWARE
MURPHY, MD, TERRANCE P	CENTRE
MURPHY, MD, THOMAS W	PHILADELPHIA
MURPHY, MD, TIMOTHY J	PHILADELPHIA
MURPHY, MD, WINDELL H A	PHILADELPHIA
MURPHY JR, MD, ARTHUR I	ALLEGHENY
MURPHY JR, MD, RAYMOND A	PHILADELPHIA
MURPHY JR, MD, ROBERT X	LEHIGH
MURR III, MD, GEORGE A	PHILADELPHIA
MURRAY, MD, CARROLL A	JEFFERSON
MURRAY, MD, CHERYL L	YORK
MURRAY, MD, JOHN P	MONTGOMERY
MURRAY, JOSEPH F	STUDENT
MURRAY, DO, MICHAEL L	BUCKS
MURRAY, MD, PATRICK M	WYOMING
MURRAY, MD, RICHARD C	CAMBRIA
MURRAY, MD, RICHARD S	BUCKS
MURRAY, MD, STEPHEN R	NORTHAMPTON
MURRAY, MD, THOMAS R	PHILADELPHIA
MURRAY, DO, WILLIAM C	BRADFORD
MURRAY, MD, WILLIAM M	DAUPHIN
MURRAY-LEISURE, MD, KATHERINE A	LEBANON
MURTAGH JR, MD, FREDERICK	PHILADELPHIA
MURTHY, MD, MOLAKALMURU H	ALLEGHENY
MURTHY, MD, MSJ	PHILADELPHIA
MURTLAND, MD, ALBERT M	BRADFORD
MUSA, MD, ALIMAD N	CARBON
MUSGRAVE, MD, ROSS H	ALLEGHENY
MUSHO, MD, MICHAEL A	MONTGOMERY
MUSKAT, MD, DAVID I	ALLEGHENY
MUSMANNO, MD, SAMUEL A	ALLEGHENY
MUSSELMAN, MD, KIRK F	BRADFORD
MUSSER, MD, BENJAMIN G	DAUPHIN
MUSSER, MD, WILLIAM T	UNION
MUSSER JR, MD, HAROLD E	SOMERSET
MUSSEY, MD, STEVEN W	FRANKLIN
MUSSOLINE, MD, JOSEPH F	PHILADELPHIA
MUSTIN, MD, ANDREW J	PHILADELPHIA
MUSTOVIC, MD, ELLEN H	BUTLER
MUTHA, MD, SUNITA	ALLEGHENY
MUTSCHLER, MD, THOMAS A	ALLEGHENY
MUTTREJA, MANOJ R	STUDENT
MYCHAK, MD, DENNIS R	NORTHUMBERLAND
MYEROWITZ, MD, RICHARD L	ALLEGHENY
MYERS, MD, ABRAHAM	PHILADELPHIA
MYERS, MD, ALLEN R	PHILADELPHIA
MYERS, MD, AMY A	LANCASTER
MYERS, MD, ANDREW H	ALLEGHENY
MYERS, BETH A	STUDENT
MYERS, MD, CHARLES E	LUZERNE
MYERS, MD, COLLIN L	YORK
MYERS, MD, DANIEL T	STUDENT
MYERS, MD, DAVID	PHILADELPHIA
MYERS, MD, EUGENE N	ALLEGHENY
MYERS, MD, FREDERICK B	LUZERNE
MYERS, MD, G BRADFORD	YORK
MYERS, MD, GERALD I	ALLEGHENY
MYERS, MD, GORDON D	DAUPHIN
MYERS, MD, JEFFREY N	ALLEGHENY
MYERS, DO, JOHN H	LANCASTER
MYERS, MD, JOHN L	DAUPHIN
MYERS, MD, LARRY S	ALLEGHENY
MYERS, MD, MARTIN A	MONTGOMERY
MYERS, MELISSA A	STUDENT
MYERS, MD, PHILIP A	BUCKS
MYERS, MD, SCOTT ELLIOT	PHILADELPHIA
MYERS III, MD, FRANKLIN J	DAUPHIN
MYERSON, MD, RALPH M	PHILADELPHIA
MYRON, MD, CAROL S	ALLEGHENY
MYSLEWSKI, MD, WALTER J	WESTMORELAND
MYSTAKAS, MD, FOTIS G	LEBANON

N

NABATCHI, MD, AHMAD	CLARION
NABATI, MD, ISMAIL	NORTHAMPTON
NABAVI, MD, ABDOLLAH	CENTRE
NACHLIS, MD, ALLAN D	DELAWARE
NACHMAN, MD, JEFFREY A	PHILADELPHIA
NACK, MD, STEVEN L	MONTGOMERY
NACKLEY, MD, DANIEL A	LUZERNE
NADAL, MD, RAMON B	BUCKS
NADEL, MD, MARCELL-BERNH	PHILADELPHIA
NADER, MD, JOSEPH N	LEHIGH
NADLER, MD, DANIEL J	ALLEGHENY
NADLER, MD, LEIGH H	ALLEGHENY
NADLER, MD, M PRINCETON	ALLEGHENY
NADWORNY, MD, HOWARD A	ERIE
NAEGLE, MD, MATTHEW B	CHESTER
NAFZIGER, MD, J CALVIN	LANCASTER
NAGARAJAN, RAJARAM	STUDENT
NAGEL, MD, DAVID B	LYCOMING
NAGELBERG, MD, STEVEN B	MONTGOMERY
NAGELKIRK, MD, JOAN E	ALLEGHENY
NAGIN, MD, JOSHUA G F	ALLEGHENY
NAGLE, MD, ARLINGTON A	BERKS
NAGLE, MD, DOUGLAS B	ERIE
NAGLE, MD, RICHARD W	ERIE
NAGLE, MD, W WILLIAM	DELAWARE
NAGLE, MD, WARREN C	BRADFORD
NAGLE, MD, WILLARD F	DELAWARE
NAGLE JR, MD, FRANK O	PHILADELPHIA
NAGPAL, MD, NARESH C	LYCOMING
NAGY, MD, CHRISTINE L	ALLEGHENY
NAGY, MD, ROBERT	BERKS
NAIBERT, MD, JAMES R	MIFFLIN/JUNI
NAIDE, MD, DAVID	PHILADELPHIA
NAIDE, MD, MEYER	PHILADELPHIA
NAIDOFF, MD, MICHAEL A	PHILADELPHIA
NAIDS, MD, RICHARD E	PHILADELPHIA

NAIDU, MD, JAI P	LYCOMING
NAIK, MD, VAISHALI D	ERIE
NAIR, MD, KRISHNAN K	ERIE
NAIR, MD, MADHUSUDANAN	ALLEGHENY
NAIR, MD, SOMNATH N	PHILADELPHIA
NAIR, MD, V KRISHNAN	SOMERSET
NAJARIAN, DO, MICHAEL P	CAMBRIA
NAJI, MD, ALI	PHILADELPHIA
NAJI, MD, MOHAMMED H	LAWRENCE
NAJMI, MD, MOOSA	NORTHAMPTON
NAKAWATASE, TOMOKO V	STUDENT
NAKHJAVAN, MD, FRED K	PHILADELPHIA
NAKHJAVAN, MICHAEL	STUDENT
NAKISPENDI, KARA M	STUDENT
NAKKACHE, MD, VICTOR B	LUZERNE
NALBANTIAN, MD, MICHEL S	PHILADELPHIA
NALEVANKO, MD, ALBERT M	LACKAWANNA
NALIN, MD, DANIEL J	ALLEGHENY
NALIN, MD, DAVID R	PHILADELPHIA
NALLATHAMBI, MD, HELGA N	BUTLER
NALLATHAMBI, MD, SWAMIKKAN A	BUTLER
NALVEN, MD, LISA M	ALLEGHENY
NAMEY, MD, JOHN T	MERCER
NAMJOSHI, MD, SHASHIKALA D	PHILADELPHIA
NANCHERLA, MD, LATHA	ALLEGHENY
NANCHERLA, MD, PRAKASH R	ALLEGHENY
NANCOLLAS, MD, PAUL H	MIFFLIN/JUNI
NANGIA, MD, SUSHMA R	ALLEGHENY
NANJUNDASWAMY, MD, HUNASAGATTA C	LAWRENCE
NANSTEEL JR, MD, JOHN F	DELAWARE
NAPIERKOWSKI, DO, STANLEY A	PHILADELPHIA
NAPLES, MD, JERRY F	BUCKS
NAPOLEON, MD, LOUIS N	ALLEGHENY
NAPPI, MD, DOMINIC F	PHILADELPHIA
NAPS, MD, MICHELLE S	MONTGOMERY
NARASIMHAN, MD, SEETHALAKSHMI	ALLEGHENY
NARAYANAN, MD, EDATHIL K	BRADFORD
NARAYANAN, MD, SURYA	BRADFORD
NARDELLA JR, MD, GUY M	DELAWARE
NARDONE, MD, DONALD T	PHILADELPHIA
NARDUZZI, MD, JOANN V	ALLEGHENY
NARLA, MD, SUDHIR K	ALLEGHENY
NARROW, MD, CHARLES M	BLAIR
NARTATEZ, MD, PEDRO C	CLEARFIELD
NARULA, MD, AMRIT P	SCHUYLKILL
NARUS, MD, VITOLD T	ERIE
NARVAEZ, MD, RICHARD A	PHILADELPHIA
NASCA, MD, LEONARDO S	ERIE
NASE, MD, DONALD F	BUCKS
NASE, MD, P KENNETH	BERKS
NASE, MD, PAUL M	BUCKS
NASEEM, MD, MOHAMMAD	ALLEGHENY
NASER, MD, JEFFREY A	PHILADELPHIA
NASH, MD, DAVID S	PHILADELPHIA
NASH, MD, JAMES D	LANCASTER
NASO, MD, FRANCIS	PHILADELPHIA
NASRI, MD, HAMZEH	DELAWARE
NASSEF JR, MD, LOUIS A	MONTOUR
NASSIRI-RAHIMI, MD, CYRUS	PHILADELPHIA
NASSUR, MD, ADNAN K	WESTMORELAND
NAST, MD, MAX S	BUTLER
NAST, MD, PHILIP R	PHILADELPHIA
NASUTI, JOSEPH F	STUDENT
NATALE, MELISSA A	STUDENT
NATALI, MD, DANIEL E	ALLEGHENY
NATHAN, DAVID L	STUDENT
NATHAN, MD, RADHA	LACKAWANNA
NATHANSON, MD, JULIET E	PHILADELPHIA
NATICCHIA, MD, JENNIFER M	STUDENT
NATIVIDAD, MD, NITA C	MONTOUR
NATOLI, MD, THOMAS J	MONTGOMERY
NATTER, MD, HOWARD M	BUCKS
NAUGLE, MD, INGRID E	ALLEGHENY
NAUM, DO, SCOTT M	ALLEGHENY
NAUM III, DO, GEORGE P	BEAVER
NAUNCZEK, MICHAEL J	STUDENT
NAUSS, MD, DAVID C	NORTHAMPTON
NAUSS, MD, THOMAS J	LUZERNE
NAVALGUND, MD, KRUPA A	ALLEGHENY
NAVARRO, MD, CYRILDA	BUCKS
NAYAK, MD, NARAYAN P	MCKEAN
NAYAK, MD, NARAYAN T	ALLEGHENY
NAYAK, MD, SATISH R	SOMERSET
NAYAK, MD, SHANTERI U	WESTMORELAND
NAYAR, MD, SUDHA M	WASHINGTON
NAZAR, MD, JOSE E	BRADFORD
NAZARI, MD, AHMAD	PHILADELPHIA
NAZZARO, MD, RALPH	VENANGO
NEAGOY, MD, DANIEL R	ERIE
NEAL, MD, HUNTER S	DELAWARE
NEAL, MD, ROLAND A	ALLEGHENY
NEAL JR, MD, HARRY B	INDIANA
NEALE, MD, JOHN M	INDIANA
NEALIS, MD, HENRY J	MONTGOMERY
NEBEKER, JONATHAN R	STUDENT
NECAS, MD, MICHAEL G	VENANGO
NEDRESKY, MD, JOSEPH P	ERIE
NEDWICH, MD, ALEXANDER	LEHIGH
NEE JR, MD, MARTIN P	ALLEGHENY
NEEFE, MD, D LYNNE	CHESTER
NEELEY, MD, STEVEN W	BEAVER
NEELY, MD, EILEEN P	ALLEGHENY
NEFCY, MD, PETER M	CAMBRIA
NEFF, MD, CHARLES A	LEBANON
NEFT, MD, BURTON H	ALLEGHENY
NEGREY JR, MD, JOHN N	DELAWARE
NEGRI, MD, ANN M	ALLEGHENY
NEGRO, MD, ATTILIO G	WESTMORELAND
NEGRON, MD, ANGEL M	ERIE
NEIBERG, DO, MARC H	DELAWARE
NEIDHARDT, MD, PAUL W	LANCASTER
NEIFELD, MD, KENNETH A	PHILADELPHIA
NEIGH, MD, JOHN L	PHILADELPHIA
NEILL, DO, THOMAS H	NORTHAMPTON
NEILSON, MD, ROBERT N	MONTGOMERY
NEILSON, MD, THOMAS J	ALLEGHENY
NEIMAN, MD, HARVEY L	ALLEGHENY
NEIMAN, MD, LEE M	ALLEGHENY
NEJMAN, MD, JOSEPH H	MONTGOMERY
NELL-BADRA, MD, ROCIO E	MONTGOMERY
NELLHAUS, MD, KURT M	ALLEGHENY
NELSON, MD, ANDERS P	LACKAWANNA
NELSON, MD, BARRY K	MONTGOMERY
NELSON, MD, BEVERLY P	PHILADELPHIA
NELSON, MD, EDWARD A	YORK
NELSON, MD, ELEANOR C	PHILADELPHIA
NELSON, MD, FREDRIC P	PHILADELPHIA
NELSON, MD, GUY M	PHILADELPHIA
NELSON, MD, HYUN-JU	DAUPHIN
NELSON, MD, JAMES E	LUZERNE
NELSON, MD, LEONARD B	PHILADELPHIA
NELSON, MD, MORTIMER T	BUCKS
NELSON, MD, PAUL B	ALLEGHENY
NELSON, MD, PHILIP K	LYCOMING
NELSON, MD, STEPHEN C	DELAWARE
NELSON, MD, THEODORE C	ALLEGHENY
NELSON, MD, WALDO E	PHILADELPHIA
NELSON JR, MD, HARRY M	MONTGOMERY
NEMANI, MD, PANDHARINATH	WASHINGTON
NEMEC, MD, JOHN E	WESTMORELAND
NEMERSON, STEVEN F	STUDENT
NEMEZ, MD, ALBERT	PHILADELPHIA
NEMEZ, MD, JACK S	PHILADELPHIA
NEMIROFF, MD, RICHARD L	PHILADELPHIA
NEMZOFF, MD, SOL L	MONTGOMERY
NEBBITT, MD, ALEXANDER R	LYCOMING
NEBBITT, MD, JOHN B	CRAWFORD
NEBBITT, MD, RICHARD A	COLUMBIA
NESI, MD, DANIEL A	BUCKS
NESPER, MD, JAMES A	INDIANA
NESPOLA, MD, ANTHONY M	TIOGA
NESPOLI, MD, ANTHONY M	NORTHUMBERLAND
NESSEL, CHRISTOPHER C	STUDENT
NESTICO, MD, PASQUALE F	PHILADELPHIA
NETTROUR, MD, LEWIS F	ALLEGHENY
NETTROUR III, MD, W SCOTT	ALLEGHENY
NETTROUR IV, MD, WALTER S	ALLEGHENY
NEUFELD, STEVEN K	STUDENT
NEUMAN, PAUL C	STUDENT
NEUMANN, DO, GREGG C	PHILADELPHIA
NEUREUTER, MD, LOUIS J	LANCASTER
NEUSCHWANDER, MD, DAVID C	ALLEGHENY
NEVILLE, MD, EDWIN C	LACKAWANNA
NEVINS, DIANA L	STUDENT
NEVULIS, MD, JOHN J	MONTGOMERY
NEVYAS, MD, HERBERT J	PHILADELPHIA
NEVYAS, MD, JOANN Y	MONTGOMERY
NEVYAS-WALLACE, MD, ANITA S	PHILADELPHIA
NEW, BARBRA S	STUDENT
NEW, MELINDA S	STUDENT
NEWBERG, MD, AARON N	PHILADELPHIA
NEWBERG, MD, JAY A	ALLEGHENY
NEWBROUGH, MD, ROBERT S	PHILADELPHIA
NEWCOMER, MD, DAVID L	LANCASTER
NEWELL, MD, PAUL M	ERIE
NEWHOUSE, MD, JOSEPH J	WESTMORELAND
NEWKIRK, MD, JOHN D	CENTRE
NEWMAN, MD, ANDREW	PHILADELPHIA
NEWMAN, MD, BENJAMIN E	PHILADELPHIA
NEWMAN, MD, DONALD A	SCHUYLKILL
NEWMAN, MD, ERIC D	MONTOUR
NEWMAN, MD, FRANK W	DELAWARE
NEWMAN, MD, GARY A	MONTGOMERY
NEWMAN, MD, LEROY	PHILADELPHIA
NEWMAN, MD, WILLIAM R	BEDFORD
NEWMAN, MD, WILLIAM T	WESTMORELAND
NEWMAN III, MD, WILLIAM H	LACKAWANNA
NEWMAN JR, MD, CLYDE F	MONTGOMERY
NEWMARK, MD, ARTHUR R	PHILADELPHIA
NEWSOM, MD, JOHN H	BUCKS
NEWTON, MD, CHARLES T	LACKAWANNA
NEWTON, MD, E DOUGLAS	ALLEGHENY
NEWTON, MD, FREDERICK C	DAUPHIN
NEWTON, MD, REX H	ALLEGHENY
NEY, MD, EUGENE C	ALLEGHENY
NEY, MD, F GREGG	BUTLER
NEYLON, MD, MICHAEL P	ERIE
NEYMAN, MD, FREYDA	PHILADELPHIA
NGEOW, MD, YIN K	FRANKLIN
NGINYO, MD, JOSPHAT A	CAMBRIA
NGUYEN, MD, BACH V	DELAWARE
NGUYEN, MD, DE	ALLEGHENY
NGUYEN, MD, HONG T	YORK
NGUYEN, MD, HUNG Q	STUDENT
NGUYEN, MD, KENNETH V	PHILADELPHIA
NGUYEN, KEVIN K	STUDENT
NGUYEN, MD, MINH Q	NORTHAMPTON
NGUYEN, MD, MINHLY T	LEHIGH
NGUYEN, MD, NGHI V	ALLEGHENY
NGUYEN, MD, NHIEN D	LEBANON
NGUYEN, MD, THACH N	DAUPHIN
NGUYEN, THANG P	STUDENT
NGUYEN, MD, TINH-CHAU	ALLEGHENY
NGUYEN, TRAN H P	STUDENT
NIBBELINK, MD, DONALD W	PHILADELPHIA
NICASSIO, MD, ANTHONY	ALLEGHENY
NICASTRO, MD, GENNARO C	PHILADELPHIA
NICHAMIN, MD, LOUIS D	CLARION
NICHINI, MD, FRANCO M	CHESTER
NICHOLAS, ANGELA M	STUDENT
NICHOLAS, MD, BRADLEY E	YORK
NICHOLAS, MD, GARY G	LEHIGH
NICHOLAS, MD, JAMES L	YORK
NICHOLAS, MD, LESLIE	PHILADELPHIA
NICHOLAS JR, MD, PETER D	BERKS
NICHOLLS, MD, JOAN E	SCHUYLKILL
NICHOLLS, MD, RICHARD H	SCHUYLKILL
NICHOLS, MD, CLAUDE E	DAUPHIN
NICHOLS, MD, DAVID P	JEFFERSON
NICHOLS, MD, WARREN W	MONTGOMERY
NICHOLS, MD, WILLIAM R	ALLEGHENY
NICHOLS JR, MD, TRENT W	YORK
NICHOLSON, MD, JOSEPH T	MONTGOMERY
NICHOLSON JR, MD, WALTER J	YORK
NICKENS, MD, OSWALD J	ALLEGHENY
NICKEBON, MD, ROBERT W	ALLEGHENY
NICKLAS, MD, DONALD A	CHESTER
NICKLAS, MD, GILBERT L	CLINTON
NICOLAS, MD, RUDY J	CENTRE
NICOLAU, MARTIN F	STUDENT
NICOLO, MD, ENRICO	ALLEGHENY
NICOLOSI, MD, JOSEPH V	ALLEGHENY
NICOLSON, MD, SUSAN C	PHILADELPHIA
NICY, MD, NADIJA L	PHILADELPHIA
NIDO, MD, MICHAEL P	CAMBRIA
NIEDELMAN, MD, MEYER L	PHILADELPHIA
NIEDERMAYER, MD, GEORGE H	PHILADELPHIA
NIELAND, MD, MICHAEL L	ALLEGHENY
NIELAND, MD, NANCY S	ALLEGHENY
NIELSEN, MD, R CRAIG	LYCOMING
NIELSEN, MD, ROBERT K	LEBANON
NIELSON, MD, DAVID H	PHILADELPHIA
NIES, MD, GERALD F	WASHINGTON
NIESEN, MD, EMIL T	WAYNE/PIKE
NIETO, MD, VICTOR E	BUTLER
NIEZGODA, MD, PAUL E	LUZERNE
NIGBOROWICZ, MD, RONALD J	ALLEGHENY
NIKOULA, MD, JAWDAT A	WESTMORELAND
NIMOITYN, MD, BENJAMIN S	PHILADELPHIA
NIMOITYN, MD, PHILIP	PHILADELPHIA
NINE, MD, JEFFREY S	ALLEGHENY
NINO, MD, RAYMOND F	WESTMORELAND
NISENBAUM, MD, HARVEY L	PHILADELPHIA
NISENBAUM, MD, MARCIA R	ALLEGHENY
NISHIMURA, GREGORY S	STUDENT
NISSLEY, MD, JAY M	UNION
NITKA, DO, DONNA M	CLARION
NITSKANSKY, MD, LEA	PHILADELPHIA
NITZBERG, MD, ROBERT S	ALLEGHENY
NIX, MD, COLLIER B	LYCOMING
NIX, MD, ROBERT D	ALLEGHENY
NIZEN, MD, JENNIFER S	PHILADELPHIA
NOAH, MD, JOSEPH	MONTGOMERY
NOBEL, MD, GOLDA R	PHILADELPHIA
NOBEL, MD, HELEN V	ALLEGHENY
NOBEL, MD, JOEL J	PHILADELPHIA
NOBLE, MD, ELLENETTA B	WASHINGTON
NOBLE, MD, JEYASEELAN	BUCKS
NOBLE, MD, S ROSS	BERKS
NOBLER, MD, MYRON P	ALLEGHENY
NOCHE, MD, CESAR N	FAYETTE
NODEN, MD, GEORGE T	ALLEGHENY
NOFTZGER, MD, MARTHA R	GREENE
NOLAN, MD, J PHILIP	MONTGOMERY
NOLAN, MD, SEAN	ALLEGHENY
NOLAN, MD, TERESA A	ALLEGHENY
NOLT, MD, JEFFREY S	ADAMS
NONACK, MD, PETER B	DELAWARE
NOONE, MD, JAMES P	BRADFORD
NOONE, MD, R BARRETT	PHILADELPHIA
NOORBAKHSH, MD, HOSSEIN	ALLEGHENY
NORATO, MD, JOSEPH F	DAUPHIN
NORD, MD, D SCOTT	BERKS
NORD, MD, ROLAND E	LAWRENCE
NORDEN, MD, DANIEL K	DELAWARE
NORDENBERG, MD, AARON	DAUPHIN
NORIS, MD, MARYANNE	DAUPHIN
NORK, MD, EDWARD P	LUZERNE
NORKUS, MD, GREGORY	LYCOMING
NORMINGTON III, MD, ERNEST V	MONTOUR
NORONHA, MD, ANANDPRAKASH I	DELAWARE
NORRIS, MD, CHARLES M	PHILADELPHIA
NORRIS, MD, DAVID C	ALLEGHENY
NORRIS, MD, JOHN N	MCKEAN
NORRIS, MD, ROBERT B	PHILADELPHIA
NORRIS, MD, ROBERT F	PHILADELPHIA
NORTHROP, MD, HERBERT L	MONTGOMERY
NORTHRUP, MD, BRUCE E	PHILADELPHIA
NOSHENY, MD, STANLEY Z	PHILADELPHIA
NOTARO, MD, JOHN	BEAVER
NOTHMANN, MD, BRUCE J	ALLEGHENY
NOTHSTEIN, DO, GARY D	LUZERNE
NOTTE, MICHAEL A	STUDENT
NOTZ, MD, ROBERT G	MONTOUR
NOURIAN, MD, ALI A	LACKAWANNA
NOVAK, MD, CHRISTOPHER	NORTHAMPTON
NOVAK, MD, JOSEPH F	ALLEGHENY
NOVAK, MD, KEVIN J	ERIE
NOVELLO, MD, JOHN J	CHESTER
NOVESKE, MD, F GREGORY	BRADFORD
NOVINGER, MD, QUENTIN T	LUZERNE
NOWACKI, MD, STANLEY M	MONTGOMERY
NOWAK, MD, TINA P	ALLEGHENY
NOWALK, ANDREW J	STUDENT
NOWOSWSKY, MD, TARAS	PHILADELPHIA
NOWOSLAWSKI, MD, JOSEPH F	PHILADELPHIA
NOWOTNY, MD, ANDREA Z	PHILADELPHIA
NOWROOZI, MD, KOSROW	PHILADELPHIA
NSEIR, MD, NAWAF I	WESTMORELAND
NTOSO, MD, MAY-ANGE	PHILADELPHIA
NUCUM, MD, AFRODISIO N	LEBANON
NULL, MD, HARRY M	ALLEGHENY
NULLET, MD, FRANCIS R	ERIE
NUNEZ, MD, HERMES	ALLEGHENY
NUNGESSER, MD, RAYMOND F	COLUMBIA
NUNNA, MD, NAGABHUSHANAM	BUTLER
NURBHAI, MD, MURTAZA E	POTTER
NUSBAUM, MD, MOREYE	PHILADELPHIA
NUSCHKE, MD, JOHN D	BUCKS
NUSSBAUM, MD, ALLEN S	YORK
NUSSBAUM, MD, ARTHUR J	ALLEGHENY
NUSSBAUM, MD, STEVEN J	DELAWARE
NUTT III, MD, JAMES N	MONTGOMERY
NUTTER, MD, DAVID E	LANCASTER
NUTTING, MD, RON D	BERKS
NUTZ JR, MD, JOSEPH F	STUDENT
NYPAVER, MD, ANNETTE L	CHESTER

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O'BANION, MD, KATHLEEN S	PHILADELPHIA
O'BOYLE, DO, LOUIS J	DAUPHIN
O'BRIEN, ERIN M	STUDENT
O'BRIEN, MD, JAMES J	MONTGOMERY
O'BRIEN JR, MD, RICHARD J	LYCOMING
O'CONNELL, MD, BRENT J	DAUPHIN
O'CONNELL, MD, JAMES P	INDIANA
O'CONNOR, MD, ELLEN M	PHILADELPHIA
O'CONNOR, MD, THOMAS W	LANCASTER
O'DEA, MD, THOMAS P	DELAWARE
O'DONNELL, MD, WARD J	DELAWARE
O'DONOGHUE, MICHAEL J	STUDENT
O'GRADY, MD, TIMOTHY J	PHILADELPHIA
O'HARA, MD, A EDWARD	PHILADELPHIA
O'HARA JR, MD, JOHN J	CHESTER
O'HEARN, MD, DANIEL J	ALLEGHENY
O'KEEFE, MD, JULIE A	ALLEGHENY
O'MALLEY, MD, DONALD F	ALLEGHENY
O'MALLEY, ERIN A	STUDENT
O'MALLEY, MD, JOHN E	CHESTER
O'MALLEY, MD, JOSEPH F	MONTGOMERY
O'MALLEY, MD, KEVIN B	PHILADELPHIA
O'ROARK, DO, DANIEL M	ALLEGHENY
O'ROURKE, MD, JOHN N	MONTOUR
O'ROURKE, MD, TERENCE L	MONTOUR
O'TOOLE, MD, THOMAS P	ALLEGHENY
OAKS JR, MD, WILBUR W	PHILADELPHIA
OAMI, MD, SHIMON	PHILADELPHIA
OBENRADER, MD, MARK F	MONTGOMERY
OBENREDER, DO, THOMAS L	ERIE
OBER, MD, HENRY E	WESTMORELAND
OBERFIELD, MD, WILLIAM J	DELAWARE
OBLEY, MD, DAVID L	ALLEGHENY
OBOYLE, MD, THOMAS A	LACKAWANNA
OBRIEN, CHRISTINE M	STUDENT
OBRIEN, MD, EDWARD T	ERIE
OBRIEN, MD, JAMES S	UNION
OBRIEN, MD, ROBERT G	ALLEGHENY
OBRIEN, MD, WILLIAM R	PHILADELPHIA
OBRIEN II, MD, JOHN S	PHILADELPHIA
OBRIEN III, MD, FRANK D	LUZERNE
OCAMPO, MD, RENATO G	MCKEAN
OCHENRIDER, MD, PAUL D	YORK
OCHOA, MD, E RICARDO	ALLEGHENY
OCHOCO-CAVANAUGH, MD, LILLIAN A	ALLEGHENY
OCKRYMIEK, DO, DOUGLAS A	LANCASTER
OCONNELL, MD, C LEONARD	GREENE
OCONNELL, MD, JAMES R	DELAWARE
OCONNOR, MD, JOHN P	ALLEGHENY
OCONNOR, MD, JOHN V	VENANGO
OCONNOR, MD, LEO E	CAMBRIA
OCONNOR, MD, MARY K	ALLEGHENY
OCONNOR, MD, MAUREEN E	PHILADELPHIA
OCONNOR, MD, MICHAEL J	PHILADELPHIA
OCONNOR, MD, WILLIAM F	BEAVER
OCONNOR JR, MD, JAMES J	LACKAWANNA
OCONOR, MD, LORRAINE M	PHILADELPHIA
OCONOR JR, MD, G THOMAS	LANCASTER
ODDI, MD, FREDERICK J	ALLEGHENY
ODIM, MD, USIM	ALLEGHENY
ODONNELL, MD, CHRIS T	ALLEGHENY
ODONNELL, MD, CHRISTINE S	BUCKS
ODONNELL, MD, GEORGE J	LUZERNE
ODONNELL, MD, WALTER F	ALLEGHENY
ODORISIO, MD, LYNNE A	PHILADELPHIA
ODORIZZI, DO, MARK G	LYCOMING
OEHRLE, MD, JOHN S	ALLEGHENY
OELS, MD, HELEN C	MONTGOMERY
OESTERLING JR, MD, EVERETT F	ALLEGHENY
OFFERMAN, MD, JOOP	ALLEGHENY
OFFNER, MD, THEODORE W	PHILADELPHIA
OFOGH, MD, KAVEH	PHILADELPHIA
OGLE, MD, KIM	ALLEGHENY
OGUN, DAVID J	STUDENT
OGUNRO, MD, CHARLES O	MERCER
OH, MD, CHANG W	LEBANON
OH, MD, JANG K	PHILADELPHIA
OH, MD, KOOK-SANG	ALLEGHENY
OH, MD, SUNG-KYU H	PHILADELPHIA
OH, MD, YONG W	LUZERNE
OHANISSIAN, MD, HANRICK G	DELAWARE
OHARA, MD, KEVIN R	ALLEGHENY
OHEARNE, MD, JOHN S	WAYNE/PIKE
OHL, MD, BETTINA M G	ADAMS
OKAGAWA, MD, RICK	PHILADELPHIA
OKANE, PATRICK L	STUDENT
OKEN, MD, DONALD	PHILADELPHIA
OKEREKE, MD, ENYI	PHILADELPHIA
OKOLIE, PATIENCE N	STUDENT

OKUNSKI, MD, WALTER J	LEHIGH
OLAH, MD, GEORGE W	ALLEGHENY
OLASIN, DO, REGINA F	TIOGA
OLBRICH, MD, CHRISTOPHER D	STUDENT
OLEAGA, MD, JUAN A	PHILADELPHIA
OLEARCHYK, MD, ANDREW S	PHILADELPHIA
OLECK, JOANNE R	STUDENT
OLENGINSKI, MD, THOMAS P	LYCOMING
OLEWILER, MD, SCOTT D	BERKS
OLEWILER JR, MD, H NEWTON	NORTHAMPTON
OLIM, MD, DAVE B	MONTGOMERY
OLIN, MD, STEPHEN T	LANCASTER
OLINSKY, MD, STUART M	LYCOMING
OLIVENSTEIN, MD, ALAN E	ALLEGHENY
OLIVER, MD, GLEN L	LEHIGH
OLIVER, MD, JOHN G	NORTHAMPTON
OLIVER, MD, ORLANDO P	WESTMORELAND
OLIVER III, MD, JAMES H	ALLEGHENY
OLIVES, MD, MANUEL	DAUPHIN
OLIVIERI, MD, SUZANNE P	MONTGOMERY
OLKEN, MD, MARK D	PHILADELPHIA
OLKOWSKI, MD, STEVEN T	YORK
OLLER, MD, SAMUEL	MONTGOMERY
OLNEY, MD, FRANKLIN B	CENTRE
OLSEN, MD, KARL R	ALLEGHENY
OLSEN, MD, KEVIN H	LACKAWANNA
OLSEN, LISA A	STUDENT
OLSHEMSKI, MD, FRANK C	LUZERNE
OLSHIN, MD, IRVING JOEL	PHILADELPHIA
OLSON, MD, EMIL W	MONTGOMERY
OLSON, KIM E	STUDENT
OLSON, MD, MARY K	ALLEGHENY
OLSON, MD, RONALD A	LUZERNE
OLSON, MD, RONALD P	PHILADELPHIA
OLSON, MD, STEVEN R	DAUPHIN
OMANA, MD, JESS E	BUCKS
ONEAL JR, MD, ALEXANDER H	MONTGOMERY
ONEIL, DO, ROBERT J	ALLEGHENY
ONEILL, MD, HUGH	PHILADELPHIA
ONEILL, MD, JOHN J	DELAWARE
ONEILL, SHEA A	STUDENT
ONG, MD, BIENVENIDO S	LAWRENCE
ONG, MD, GEORGE P	CUMBERLAND
ONG, MD, JIMMY J	ALLEGHENY
ONIFER, MD, THEODORE M	MONTGOMERY
ONOFREY, MD, DAVID	LACKAWANNA
ONQUE, MD, GLORIA C	ALLEGHENY
ONWUTA, MD, J NNAEMEKA	ALLEGHENY
OPALACK, DO, CHERYL A	DAUPHIN
OPASS, MD, EDWARD S	BUCKS
OPIDA, MD, CICERON L	BLAIR
OPIDA, MD, MARINA	BLAIR
OPLINGER, MD, ARTHUR F	BERKS
OPSASNICK, MD, STEPHEN G	MONTGOMERY
ORAM, MD, ALAN J	COLUMBIA
ORAM, MD, MELVIN	LACKAWANNA
ORANGE, MD, PAUL D	FRANKLIN
ORDENTLICH, MD, ELENA	PHILADELPHIA
ORDINARIO JR, MD, VICENTE R	CRAWFORD
ORDIWAY, MD, LESTER C	CHESTER
ORDIWAY, MD, M VERNON	ELK/CAMERON
ORDOUKHANIAN, ELSA	STUDENT
ORDWAY JR, MD, EUGENE E	LEHIGH
ORECCHIA, MD, PAUL M	DAUPHIN
ORELLANA, CHARLES F	STUDENT
ORELLANA, MD, JOSE R	PHILADELPHIA
OREN, MD, AHUVA	PHILADELPHIA
ORIE, MD, JOHN R	ALLEGHENY
ORIE, MD, JUDITH E	ALLEGHENY
ORIEL, MD, ROBERT J	LEHIGH
ORINICK III, MD, MICHAEL	ALLEGHENY
ORLAND, MD, STEVEN M	BUCKS
ORLANDO, DAVID C	STUDENT
ORLANDO, MD, JOSEPH D	LUZERNE
ORLANDO, MD, RALPH P	BRADFORD
ORLANDO, MD, SALVATORE J	ALLEGHENY
ORLIN, MD, STEPHEN E	MONTGOMERY
ORMAN, MD, JACK M	MONTGOMERY
ORMAN, MD, STEVEN K	DAUPHIN
ORNDORF, MD, THOMAS P	FRANKLIN
ORNE, MD, MARTIN T	PHILADELPHIA
ORONS, DO, PHILIP D	ALLEGHENY
ORPHANIDES, MD, TIMOTHY	BUCKS
ORQUIZA, MD, CLODUALDO S	BERKS
ORR, MD, ALEXANDER S	BRADFORD
ORR, MD, DONALD P	ALLEGHENY
ORR, MD, PAUL L	LEHIGH
ORR JR, MD, ROSS M	NORTHAMPTON
ORRINGER, MD, DAVID	ALLEGHENY
ORRIS, MD, DONALD J	JEFFERSON
ORSINI, MD, MICHAEL A	BEAVER
ORTEGA, DO, KENNETH D	BRADFORD
ORTEGA, MARCOS R	STUDENT
ORTIZ, MD, NYRMA N	PHILADELPHIA
ORTIZ, MD, ROBERTO	CAMBRIA
ORTLEY, DO, GLENN R	DELAWARE
ORVIS, MD, HAROLD H	CHESTER
OSBERG, MD, LISA A	ALLEGHENY
OSBORN, MD, HAYLER H	MONTGOMERY
OSBORN, MD, IAN C	CENTRE
OSBORN, DO, VALENTINE M	CUMBERLAND
OSBORNE, MD, DAVID P	MCKEAN
OSCHWALD, MD, CHARLES J	CAMBRIA
OSGOOD, MD, CARROLL P	BLAIR
OSHEKA, MD, WILLIAM	ALLEGHENY
OSHEROFF, MD, JEROME A	ALLEGHENY
OSHEROFF, MD, JOSEPH E	PHILADELPHIA
OSIAL JR, MD, THADDEUS A	ALLEGHENY
OSIAS, MD, MARC B	MONTGOMERY
OSIFCHIN, MD, NICOLE E	ALLEGHENY
OSKANIAN, FREDERICK	STUDENT
OSKIN, TIMOTHY C	STUDENT
OSLICK, MD, THEODORE	PHILADELPHIA
OSMANSKI, MD, STEPHEN J	ALLEGHENY
OSMICK, MD, MARY J	PHILADELPHIA
OSOFSKY, MD, MURRAY V	ALLEGHENY
OSORIO, MD, EMMANUEL P	PHILADELPHIA
OSOWSKI, MD, THAD	WASHINGTON
OSTDAHL, MD, ROGER H	DAUPHIN
OSTER, MD, JOHN G	NORTHAMPTON
OSTERHOLM, MD, JEWELL L	PHILADELPHIA
OSTERHOUDT, MD, KEVIN C	PHILADELPHIA
OSTERMAN, MD, A LEE	PHILADELPHIA
OSTFELD, MD, DAVID A	NORTHAMPTON
OSTMAN, MD, ZENAIDA E	DAUPHIN
OSTROWSKI, DO, CHARLES A	ELK/CAMERON
OSTRUM, MD, BERNARD J	PHILADELPHIA
OSTRUM, MD, DONALD S	PHILADELPHIA
OTERO, MD, SUSANNE I	PHILADELPHIA
OTOOLE, MD, JAMES D	ALLEGHENY
OTOOLE, MD, THOMAS F	PHILADELPHIA
OTT, MD, CAROL E	MONTGOMERY
OTTENBERG, MD, DONALD J	PHILADELPHIA
OTTERY, MD, FAITH D	PHILADELPHIA
OTTONELLO, MD, DOMINGO G	ALLEGHENY
OU, MD, KUANG-YU	ALLEGHENY
OUANO, MD, ROMEO C	LUZERNE
OVERBECK, MD, MICHAEL D	MONTGOMERY
OVERFIELD, MD, EDWARD M	ERIE
OVERLY, MD, WYLIE L	WESTMORELAND
OWENS, MD, DAVID E	LUZERNE
OWENS, MD, E REESE	ALLEGHENY
OWENS, DO, EDWARD J	CRAWFORD
OWENS, MD, ERIK L	DAUPHIN
OWENS, MD, JOHN D	YORK
OYER, MD, RANDALL A	PHILADELPHIA
OYLER, MD, GEORGE A	DAUPHIN
OYOYO, UGOCHI A	STUDENT
OZAKI, WAYNE	STUDENT
OZOLEK, MD, JOHN A	ALLEGHENY

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PACANA, SUSAN M	STUDENT
PACANOWSKI, MD, JOHN P	BRADFORD
PACE, MD, JOSEPH N	PHILADELPHIA
PACEK, MD, ROBERT F	ARMSTRONG
PACHTMAN, MD, ISADORE	ALLEGHENY
PACIFICO, MD, RONALD L	ALLEGHENY
PACIOTTI, MD, SAMUEL M	MONROE
PACIS, MD, CONSTANTE D	NORTHAMPTON
PACIULLI, MD, RAFFAELE	BERKS
PACKER, MD, JEFFREY E	LANCASTER
PACKER, MD, LESLIE A	MONTOUR
PACKER, MD, STUART H	BUCKS
PACKMAN, MD, BARRY E	PHILADELPHIA
PACKMAN, MD, IRA J	DAUPHIN
PACKOVICH, MD, MILAN J	WASHINGTON
PACURARIU, MD, RADU I	LUZERNE
PADALINO, MD, MICHAEL J	VENANGO
PADEN, MD, DRUE R	LUZERNE
PADGET, MD, EDWARD S	PHILADELPHIA
PADIN, MD, FREDERICO A	VENANGO
PADIYAR, MD, RAMDAS B	BERKS
PADOLINA, MD, RUBY M	PHILADELPHIA
PADULA, MD, ANTHONY M	PHILADELPHIA
PAE, MD, DONG W	WESTMORELAND
PAE, MD, WALTER E	DAUPHIN
PAEZ, MD, EDUARDO J	PHILADELPHIA
PAGALILAUAN, MD, MANUEL A	PHILADELPHIA
PAGAN, MD, HECTOR C	BEAVER
PAGAN, MD, JOHN J	PHILADELPHIA
PAGANA, MD, JOHN P	NORTHUMBERLAND
PAGANA, MD, TIMOTHY J	LYCOMING
PAGANA, MD, WILLIAM J	MONTOUR
PAGANA II, MD, CHARLES C	LYCOMING
PAGANO, MD, ROBERT J	ALLEGHENY
PAGE, MD, MICHAEL J	DAUPHIN
PAGE, MD, ROBERT B	DAUPHIN
PAGE JR, MD, EDWIN H	BEAVER
PAGNANELLI, MD, DAVID M	MONTGOMERY
PAGNIELLO, MD, LUCIA	CRAWFORD
PAGNOTTO, DO, JOHN F	LYCOMING
PAI, MD, KOCHIKAR G	ALLEGHENY
PAI, MD, NARENDRA M	DAUPHIN
PAINTER, MD, MICHAEL J	ALLEGHENY
PAINTER, DO, SUSAN G	WESTMORELAND
PAIVA, MD, JOHN D	ALLEGHENY
PAK, SHANE S	STUDENT
PALANDJIAN, MD, KHATCHADOUR B	LACKAWANNA
PALANISAMY, MD, SUBRAMANIAM	ALLEGHENY
PALANT, MD, MARINA B	PHILADELPHIA
PALARSKI, MD, JEFFREY D	ALLEGHENY
PALAT, DO, HERMAN W	PHILADELPHIA
PALATKA, MD, ANDREW A	LAWRENCE
PALENA, MD, PETER V	DELAWARE
PALETTA, JOHN D	STUDENT
PALIN, MD, WILLIAM E	BEDFORD
PALKOVITZ, MD, HARRY P	ALLEGHENY
PALLADINO, MD, DIANE P	PHILADELPHIA
PALLAN, MD, LAURA A	ALLEGHENY
PALLAS, MD, RANDOLPH S	BERKS
PALLEN, MD, DANIEL	LANCASTER
PALLITTO, MD, LORRAINE R	BUCKS
PALLONE, DO, LESLIE T	BEAVER
PALMA, DOUGLAS A	STUDENT
PALMER, MD, ARTHUR H	ALLEGHENY
PALMER, MD, KATHLEEN M	PHILADELPHIA
PALMER, MD, MICHAEL H	FRANKLIN
PALMER, MD, ROBERT H	PHILADELPHIA
PALMER JR, MD, DALE H	CENTRE
PALMER JR, MD, WILLIAM E	CAMBRIA
PALMER-BRADSHAW, JOSETTE C	STUDENT
PALMEROLA, MD, RAFAEL A	ALLEGHENY
PALOMBO, MD, CHRISTOPHER J	ALLEGHENY
PALUMBO, SALVATORE J	STUDENT
PALUS, MD, BERNARD R	ALLEGHENY
PALUSHOCK, MD, SHARON	LACKAWANNA
PALUSO, MD, EUGENE F	WASHINGTON
PALUSO, MD, JOHN R	WASHINGTON
PAN, MD, EDWARD L	BERKS
PANAHANDEH, MD, ABOLHASSAN	ALLEGHENY
PANARO, MD, RUDOLPH J	MONTGOMERY
PANAYOTOVA, MD, MARIA L	NORTHAMPTON
PANCHAL, MD, PRAVIN D	ALLEGHENY
PANCOAST, MD, STEPHEN J	LACKAWANNA
PANDELIDIS, MD, P KIRK	YORK
PANDELIDIS, MD, STEVE M	YORK
PANDIT, MD, DEVAYANI I	ALLEGHENY
PANDIT, MD, RASHMIKANT S	MIFFLIN/JUNI
PANDIT, MD, SANTOSH M	ALLEGHENY
PANDOLFI, MD, FRANK J	PHILADELPHIA
PANEBIANCO, MD, ANTONIO C	LEHIGH
PANETTIERI, MD, REYNOLD A	PHILADELPHIA
PANG, MD, DACHLING	ALLEGHENY
PANGBURN, MD, THOMAS L M	STUDENT
PANGILINAN, AUDWIN J	STUDENT
PANGILINAN, MD, REY T	ALLEGHENY
PANICCO, DO, RICHARD J	WASHINGTON
PANICO, MD, ROBERT A	PHILADELPHIA
PANIS, MD, ROBERTO	PHILADELPHIA
PANITCH, MD, KENNETH N	PHILADELPHIA
PANSURIA, MD, MINAXI H	PHILADELPHIA
PANTALONE, MD, ALBERT	BEAVER
PANTALONE, MD, ANGELO L	ALLEGHENY
PANTALONE, MD, FRANK A	WESTMORELAND
PANZER, MD, GLENN M	LUZERNE
PANZER, MD, HERMAN M	MONTGOMERY
PAOLINI, MD, MAURO J	BERKS
PAOLUCCI, MD, STEPHEN J	MONTOUR
PAOLUCCI, MD, SUSAN L	MONTOUR
PAPAS, MD, SPIRO N	ALLEGHENY
PAPAZIAN, MD, ARA	ALLEGHENY
PAPENDICK, MD, KEITH L	ERIE
PAPINCAK, MD, LARRY J	FAYETTE
PAPOLA, MD, JOHN S	LEHIGH
PAPPANO JR, MD, JOSEPH E	MONTGOMERY
PAPPAS, MD, MICHAEL A	ALLEGHENY
PAPPAS, MD, MICHAEL T	ALLEGHENY
PARABIA, MD, PERIN F	LACKAWANNA
PARABOSCHI, MD, CHARLES F	ALLEGHENY
PARADISE, MD, JACK L	ALLEGHENY
PARAGAS SR, MD, LAMBERTO S	CENTRE
PARAMESWARIN, MD, R	PHILADELPHIA
PARANJPE, MD, MOHAN K	ALLEGHENY
PARASCANDOLA, MD, SALVATORE A	DAUPHIN
PARCELLA, MD, PHYLLIS A	BERKS
PARCINSKI, DO, RICHARD E	CAMBRIA
PARDINE, MD, MARILYN T	WAYNE/PIKE
PARENT JR, MD, FERNAND N	WASHINGTON
PARENTI, DO, DANIEL J	PHILADELPHIA
PARENTI, MD, DENNIS L	NORTHAMPTON
PARENTI, MD, JOHN M	MONTOUR
PARESO, MD, JAMES D	WASHINGTON
PARIKH, ALEXANDER A	STUDENT
PARIKH, MD, BHARATI K	ALLEGHENY
PARIKH, MD, MUKUL L	DAUPHIN
PARIKH, MD, NEELIMA M	DAUPHIN
PARIKH, MD, SHIRISH N	BERKS
PARIS, MD, SCOT D	PHILADELPHIA
PARISI, MD, ERIKA F	DELAWARE
PARISI, MARY T	STUDENT
PARK, MD, BOYD N	BUTLER
PARK, MD, CHAN H	PHILADELPHIA
PARK, MD, CHONG H	PHILADELPHIA
PARK, MD, CHONG S	ERIE
PARK, MD, HONG S	CUMBERLAND
PARK, MD, HYUNG K	PHILADELPHIA
PARK, MD, IN-BUM	ALLEGHENY
PARK, JEANNE S	STUDENT
PARK, MD, JESSE K	ALLEGHENY
PARK, MD, JOON O	BEAVER
PARK, MD, JOSEPH M	INDIANA
PARK, JULIE U	STUDENT
PARK, MD, MIN H	FAYETTE
PARK, MD, NAE H	DAUPHIN
PARK, MD, NANCY H	ALLEGHENY
PARK, MD, NEIL I H	CAMBRIA
PARK, MD, PAULINE K	PHILADELPHIA
PARK, MD, SANG B	ALLEGHENY
PARK, MD, STEVEN E	ALLEGHENY
PARK, MD, SUNG H	SCHUYLKILL
PARK, MD, THOMAS E	FAYETTE
PARK, MD, YOUNG W	LYCOMING
PARKER, MD, ALBERT F	CHESTER
PARKER, MD, ALBERT G	ALLEGHENY
PARKER, MD, ANDREW J	MIFFLIN/JUNI
PARKER, DONNA J	STUDENT
PARKER, DO, FRANK	CLINTON
PARKER, MD, GERALD A	WESTMORELAND
PARKER, MD, JANET A	PHILADELPHIA
PARKER, MD, JOHN S	WESTMORELAND
PARKER, MD, STEVEN L	LANCASTER
PARKIN, JEFFREY S	STUDENT
PARKS, MD, DONALD B	PHILADELPHIA
PARKS, DO, JOSEPH L	INDIANA
PARKS JR, MD, LYTLE R	CENTRE
PARLAVECCHIO, MD, DENNIS S	JEFFERSON
PARLEE, MD, DONALD E	BUCKS
PARLIMENT, MD, JOEL W	LANCASTER
PARMAR, MD, RASIK B	MIFFLIN/JUNI
PARMELEE, DO, TONI J H	LUZERNE
PARMET, MD, JONATHAN L	PHILADELPHIA
PARNES, MD, CURT I	MONTGOMERY
PARNES, MD, HERBERT M	DAUPHIN
PARONISH, MD, WILLIAM J	CAMBRIA
PARR, MD, JUSTIN L	PHILADELPHIA
PARRILLO, MD, DOUGLAS W	LACKAWANNA
PARRIS, MD, RONALD N	PHILADELPHIA
PARRIS, MD, TED M	PHILADELPHIA
PARRISH, MD, BETH	PHILADELPHIA
PARRY, MD, CAROLYN E	PHILADELPHIA
PARRY, MD, H FRAZER	PHILADELPHIA
PARRY, MD, JOHN S	MIFFLIN/JUNI
PARRY, MD, PETER	DELAWARE
PARRY, MD, RHINARD D	NORTHAMPTON
PARSICK, MD, DANIEL P	LACKAWANNA
PARSONS, EXEC SEC, ROBERT R	LEHIGH
PARTRIDGE, MD, ROBERT A	DELAWARE
PARVA, MD, GHASEM	ALLEGHENY
PARVUS, MD, DIRK F	SCHUYLKILL
PASATIEMPO, MD, ABNER P	PHILADELPHIA
PASATIEMPO, MD, ANAMARIA G	PHILADELPHIA
PASCAL, MD, HAROLD J	MONROE
PASCAL, MD, JOSEPH	LEHIGH
PASCUA, MD, ALEXANDER V	BEAVER
PASCUAL, MD, GENEROSO S	ALLEGHENY
PASCUAL, RODOLFO M	STUDENT
PASCUCCI, MD, STEPHEN E	LACKAWANNA
PASCUCCI, MD, STEPHEN E	LACKAWANNA
PASDAR, MD, HOMAYOON	DELAWARE
PASH, MD, CHRISTOPHER A	ALLEGHENY
PASHMAN, MD, DAVID R	PHILADELPHIA
PASKIN, MD, DAVID L	PHILADELPHIA
PASQUALONE, MD, MARTIN A	BUCKS
PASQUARIELLO, MD, PATRICK S	PHILADELPHIA
PASQUARIELLO, RICK D	STUDENT
PASSERO, MD, FRANK C	DELAWARE
PASTO, MD, MATTHEW E	PHILADELPHIA
PASTOR, MD, JAMES A	LEBANON
PASTORE, MD, GAETANO N	STUDENT
PASTORE, MD, TIMOTHY P	PHILADELPHIA
PATADIA, MD, CHANDRAKANT	BERKS
PATAKI, MD, RICHARD S	WASHINGTON
PATALINGHUG JR, MD, PASCUAL N	FRANKLIN
PATANKAR, MD, JAYANT L	ELK/CAMERON
PATANKAR, MD, KALPANA U	CHESTER
PATCHEFSKY, MD, ARTHUR S	PHILADELPHIA
PATCHEN JR, MD, PATRICK N	ALLEGHENY
PATEL, MD, ARUN R	BLAIR
PATEL, MD, BAKULESH D	MONTOUR
PATEL, MD, BHARAT K	LACKAWANNA
PATEL, MD, BHARTIBEN R	ALLEGHENY
PATEL, MD, BHAVNA C	BUCKS
PATEL, MD, BHUPENDRA R	LACKAWANNA
PATEL, MD, BHUPENDRA R	SUSQUEHANNA
PATEL, MD, BIPIN M	LACKAWANNA
PATEL, MD, DILIPKUMAR J	LUZERNE
PATEL, MD, GAUTAM P	ALLEGHENY
PATEL, MD, HARSHAD R	LYCOMING
PATEL, MD, HARSHADKUMAR B	LANCASTER
PATEL, MD, JAGDISH D	CAMBRIA
PATEL, MD, JAYANTILAL R	BUCKS
PATEL, MD, JAYESH	ALLEGHENY
PATEL, MD, JAYKUMAR	BUCKS
PATEL, MD, JIVANLAL M	CLARION
PATEL, MD, KANCHANLAL S	LAWRENCE
PATEL, MD, KANTILAL C	ERIE
PATEL, MD, MADHUKAR R	LEBANON
PATEL, MD, MANOJBHAI P	WASHINGTON
PATEL, MD, MANOJKUMAR R	BEAVER
PATEL, MD, MANUBHAI R	PHILADELPHIA
PATEL, MD, MINA G	ALLEGHENY
PATEL, MD, MOHAN M	WESTMORELAND
PATEL, MD, MUKESH A	DELAWARE
PATEL, MD, NAINESH M	MONTGOMERY
PATEL, MD, PRABHA H	DELAWARE
PATEL, MD, PRAKASH J	MIFFLIN/JUNI
PATEL, MD, PRAVINCHANDRA K	SUSQUEHANNA
PATEL, MD, PURSHOTTAM N	NORTHMBRLAND
PATEL, MD, RAJ J	LYCOMING
PATEL, RAJESH I	STUDENT
PATEL, MD, RAJESH J	DELAWARE
PATEL, MD, RAMESH C	LACKAWANNA
PATEL, MD, RASILA P	UNION
PATEL, MD, RITA M	ALLEGHENY
PATEL, MD, SANGNYA R	LUZERNE
PATEL, MD, SANJAY D	MONTGOMERY
PATEL, MD, SATISH D	LUZERNE
PATEL, MD, SHASHIKANT B	DAUPHIN
PATEL, SHERAL S	STUDENT
PATEL, MD, SUBODH G	FAYETTE
PATEL, SUSHMA M	STUDENT
PATEL, MD, UTHICA P	PHILADELPHIA
PATEL, MD, VINOD M	ERIE
PATEL, MD, VRINDA P	BUCKS
PATEL, MD, YOGESH P	ALLEGHENY
PATERNITI, MD, SAMUEL F	LEBANON
PATERSON, MD, KIMBERLY K	DELAWARE
PATHAK, MD, RAJANI K	JEFFERSON
PATHARE, MD, MEERA V	LEHIGH
PATHEJA, MD, JOTINDER K	WESTMORELAND
PATHROFF, MD, ROBERT	MONTGOMERY
PATIL, SUSHEEL P	STUDENT
PATNAIK, MD, RAMPRASAD	PHILADELPHIA
PATNAM, MD, SRIDHAR V	FAYETTE
PATRIARCO, DO, MICHAEL S	LEHIGH
PATRICIO, MD, ALEJANDRO M	FAYETTE
PATRICK, MD, DAVID B	BEAVER

PATRICK, MD, DAVID R	BEAVER
PATRICK, MD, GREGORY B	ALLEGHENY
PATRICK, MD, MICHAEL A	NORTHAMPTON
PATRICK, MD, TIMOTHY A	CAMBRIA
PATTANAYAK, MD, MINATI	BUCKS
PATTEN, MD, DONALD A	MONTOUR
PATTERSON, MD, CHRIS	DELAWARE
PATTERSON, MD, CHRISTOPHER J	FAYETTE
PATTERSON, MD, JOHN R	PHILADELPHIA
PATTERSON, MD, JOHN W	NORTHAMPTON
PATTERSON, MD, LELAND F	DAUPHIN
PATTERSON, MD, LEWIS T	DAUPHIN
PATTERSON, MD, RICHARD J	DAUPHIN
PATTERSON JR, MD, ARTHUR J	GREENE
PATTI, JAMES E	STUDENT
PATTISHALL III, MD, EVAN G	DAUPHIN
PATTON, MD, ANNA M	ALLEGHENY
PATTON, MD, CARLA S	BUCKS
PATTON, MD, DREUX R	DELAWARE
PATTON, MD, GEORGE D	ALLEGHENY
PATTON, MD, MARY L	DELAWARE
PATUKAS, MD, PETER C	CHESTER
PATULA, PAULA J	STUDENT
PAUL, MD, ALBERT J	PHILADELPHIA
PAUL, MD, ALVIN J	MONTGOMERY
PAUL, MD, BORIS	MONROE
PAUL, MD, CHAMPA L	BUCKS
PAUL, MD, GERSON S	PHILADELPHIA
PAUL, MD, JAY	BUTLER
PAUL, MD, JONATHAN J	PHILADELPHIA
PAUL, MD, LAURENCE H	DAUPHIN
PAUL, MD, LEENA	BERKS
PAUL, MD, PHYLLIS O	PHILADELPHIA
PAUL, MD, RICHARD	ALLEGHENY
PAUL, MD, RONALD L	YORK
PAULETTO, MD, FERREL J	DELAWARE
PAULEY, MD, LOIS P	BUCKS
PAULEY, MD, WILLIAM G	BUCKS
PAULISH, DO, JOHN W	LACKAWANNA
PAUTLER, MD, STANISLAV	ALLEGHENY
PAVLAK, MD, ROBERT J	ALLEGHENY
PAVLIC, MD, GEORGE J	ALLEGHENY
PAVLIDES, MD, CONSTANTINOS A	PHILADELPHIA
PAVLIS, MD, ROBERT J	ALLEGHENY
PAVSEK, MD, EDWARD J	ALLEGHENY
PAVUK, MD, DANIEL J	LACKAWANNA
PAWAR, MD, SURENDRA V	ALLEGHENY
PAWELSKI, MD, RICHARD J	DAUPHIN
PAWLOSKY, MD, FRANK X	ALLEGHENY
PAWLOWSKY, DO, MICHAEL	MONTGOMERY
PAXSON, DO, STEPHEN G	MERCER
PAYNE, MD, VIRGINIA L	NORTHUMBERLAND
PAZMINO, MD, ROY R	BLAIR
PEACOCK, MD, THOMAS E	NORTHAMPTON
PEAIRS, MD, RANDALL R	LACKAWANNA
PEAL, MD, STANLEY	ALLEGHENY
PEALE, MD, AUGUSTIN R	PHILADELPHIA
PEARAH, MD, J DAVID	BERKS
PEARCE, MD, STEVEN R	YORK
PEARD, MD, ROBERT J	ALLEGHENY
PEARLMAN, MD, EUGENE S	DELAWARE
PEARLSTINE, MD, BEATRICE	PHILADELPHIA
PEARMAN, MD, TREVOR J	LANCASTER
PEARSON, MD, ELYSE S	BRADFORD
PEARSON, MD, FREDERICK J	NORTHAMPTON
PEARSON, MD, JUNE A	MONROE
PEARSON, MD, THOMAS O	MIFFLIN/JUNI
PEARSON JR, MD, ROBERT E	DAUPHIN
PEART, MD, RAYMOND E	LANCASTER
PEASE, MD, FRED	CLEARFIELD
PEASE, MD, WILLIAM E	DAUPHIN
PEBERDY, MD, MARYANN	PHILADELPHIA
PECHIN, MD, BERGIUS P	DELAWARE
PECHSTEIN, MD, GEORGE R	MONTGOMERY
PECHT, MD, KARL R	CLINTON
PECK, DO, MICHAEL L	FRANKLIN
PECK, MD, WILLIAM J	LYCOMING
PECMAN, MD, JOANNA	ALLEGHENY
PECORA, MD, MICHAEL J	ALLEGHENY
PECORELLA, WENDY A	STUDENT
PEDERSON, MD, DEBRA L	PHILADELPHIA
PEER, MD, MEETA D	PHILADELPHIA
PEFF, MD, THOMAS C	PHILADELPHIA
PEGGS, MD, MICHAEL A	PHILADELPHIA
PEGUERO, MD, O ALBERTO	LUZERNE
PEIKES, MD, IRWIN L	MONTGOMERY
PEIMER, MD, MICHAEL E	DELAWARE
PEIRSOL, MD, BETTY L	ALLEGHENY
PEITZMAN, MD, ANDREW B	ALLEGHENY
PELCZAR, MD, EUGENE W	LUZERNE
PELEKANOS, MD, MICHAEL J	ALLEGHENY
PELENSKY, MD, JEANNE M	PHILADELPHIA
PELICCI, MD, LEROY J	LACKAWANNA
PELKOFER, MD, CLETUS G	ALLEGHENY
PELKOWSKI, MD, DAVID J	BRADFORD
PELLECCHIA, MD, DENNIS J	BERKS
PELLECCHIA, MD, PATRICK E	PHILADELPHIA
PELLEGRINI, MD, RONALD V	ALLEGHENY
PELLEGRINI, MD, VINCENT A	BERKS
PELLEGRINO, JOHN A	STUDENT
PELLITTERI, DO, PHILLIP K	MONTOUR
PELLIZZARI, MD, RINALDO G	ERIE
PELMAN, MD, ROBERT N	PHILADELPHIA
PELSZYNSKI, MD, EUGENE E	PHILADELPHIA
PELTZ, MD, DIETER E	MONTGOMERY
PELTZER, MD, DAVID E	ALLEGHENY
PELTZER, LETICIA I	STUDENT
PELTZER, MD, SONIA R	ALLEGHENY
PELUCIO, MD, MARCUS A	ALLEGHENY
PEMBERTON, MD, CLIFFORD H	MONTGOMERY
PENATER, MD, FRANK R	CARBON
PENCZAK, FREDERICK W	STUDENT
PENDINO, DO, ALEXANDER M	PHILADELPHIA
PENDLETON, MD, JAMES L	MONTGOMERY
PENDRAK, MD, ROBERT S	STUDENT
PENETAR, DO, MARTIN C	LUZERNE
PENG, MD, ESTER CHIH-LAN	LACKAWANNA
PENKROT, MD, RONALD J	ALLEGHENY
PENMAN, MD, WILLIAM R	CHESTER
PENN, MD, SAMUEL E	ALLEGHENY
PENNE, MD, ROBERT B	PHILADELPHIA
PENNELL, MD, REBECCA G	LANCASTER
PENNEYS, MD, EDITH T	PHILADELPHIA
PENNINGTON, MD, NEIL D	CHESTER
PENNOCK, MD, JOHN L	DAUPHIN
PENNOCK, MD, L LEWIS	ALLEGHENY
PENNOCK, MD, RONALD S	PHILADELPHIA
PENROD, MD, LOUIS E	ALLEGHENY
PENROD, MARY C	STUDENT
PENTA, MD, JOHN M	BERKS
PENUGONDA, MD, DWARAKI B	LUZERNE
PENUGONDA, MD, HARAGOPAL S	LUZERNE
PEPE, MD, PETER F	CENTRE
PEPICELLO, MD, JAMES A	ERIE
PEPPELMAN JR, DO, WALTER C	DAUPHIN
PEPPER, MD, L DOUGLAS	ALLEGHENY
PEPPERMAN, MD, LARUE E	LYCOMING
PERALTA, MD, JUAN O	NORTHUMBERLAND
PERCH, MD, GERALD A	MONTGOMERY
PERCH, MD, ROBERT B	MONTGOMERY
PERER, MD, WILLIAM A	ALLEGHENY
PERERA, MD, L WIMAL	MONTGOMERY
PEREZ, MD, ANA M	BUCKS
PEREZ, MD, ERLINDA B	FAYETTE
PEREZ, MD, GODOFREDO B	FAYETTE
PEREZ, MD, HORACIO A	ALLEGHENY
PEREZ, DO, RAYMOND J	MONTGOMERY
PEREZ, MD, RUBEN	LEBANON
PEREZ-SCHWARTZ, MD, LUZ	PHILADELPHIA
PERFETT, MD, ALFRED A	MERCER
PERILSTEIN, MD, MICHAEL D	BERKS
PERKEL, MD, ROBERT L	PHILADELPHIA
PERKINS, MD, JEFFREY C	PHILADELPHIA
PERKINS, MDN, PHILIP G	BERKS
PERLMAN, MD, ABRAHAM	PHILADELPHIA
PERLMAN, MD, HENRY H	PHILADELPHIA
PERLMAN, MD, HERBERT C	CUMBERLAND
PERLMAN, MICHAEL W	STUDENT
PERLMUTTER, MD, GORDON S	BERKS
PERLMUTTER, MD, JEFFREY A	ALLEGHENY
PERLOFF, MD, LEONARD J	PHILADELPHIA
PERLSTEIN, MD, DEBORAH A	DELAWARE
PERLSTEIN, MD, SAMUEL M	PHILADELPHIA
PERNA, MD, FRANCIS X	DAUPHIN
PERNESKI, MD, ROBERT L	ELK/CAMERON
PEROUTKA, MD, KATHRYN	DAUPHIN
PERPER, MD, JOSHUA A	ALLEGHENY
PERRI, MD, FRANCIS R	ALLEGHENY
PERRI, MD, JOHN A	ALLEGHENY
PERRIGE, MD, WILLIAM M	NORTHUMBERLAND
PERRIN, MD, RONALD L	ALLEGHENY
PERRONE, MD, FRANK F R	FAYETTE
PERRONE, MD, JEANMARIE	PHILADELPHIA
PERROTTA JR, MD, CHARLES	ALLEGHENY
PERROTTO, MD, JUDITH A	LEBANON
PERROTTO, MD, SANTLE L	PHILADELPHIA
PERRUQUET, MD, JAMES L	MONTOUR
PERRY, MD, ANTHONY M	LACKAWANNA
PERRY, MD, JAMES J	ALLEGHENY
PERRY, MD, LEE C	BEAVER
PERRY, RACHEL L	STUDENT
PERRY, MD, RAYMOND A	BRADFORD
PERRYMAN, MD, CHARLES A	ALLEGHENY
PERRYMAN, MD, CHARLES R	ALLEGHENY
PERSHING, MD, HUGH S	BUCKS
PERSIC JR, MD, LOUIS A	CENTRE
PERSING, MD, JOHN H	UNION
PESKE, MD, EDGAR D	WESTMORELAND
PESSOLANO, MD, CARL J	ALLEGHENY
PESSOLANO, MD, FRANCIS X	SOMERSET
PETACCIO, CLAUDIA J	STUDENT
PETCU, MD, DAVID J	PHILADELPHIA
PETER, MD, ANNIE	PHILADELPHIA
PETERNEL, MD, WAYNE W	ALLEGHENY
PETERS, MD, CHARLES D	LEHIGH
PETERS, MD, JEFFREY L	ALLEGHENY
PETERS, MD, JEROME A	WESTMORELAND
PETERS, MD, JOHN W	LACKAWANNA
PETERS, MD, LEONARD L	VENANGO
PETERS, MELISSA L	STUDENT
PETERS, MD, MICHAEL	BUCKS
PETERS, MD, RICHARD A	WARREN
PETERS, MD, ROBERT J	FAYETTE
PETERS, MD, SARA B	PHILADELPHIA
PETERS, MD, STANLEY F	BUCKS
PETERS, MD, VAUGHAN	ALLEGHENY
PETERS, MD, WALTER K	NORTHAMPTON
PETERS III, MD, ROBERT H	SCHUYLKILL
PETERS JR, MD, ROBERT H	LUZERNE
PETERSOHN, MD, J RANDOLPH	MONTGOMERY
PETERSON, MD, ARLEEN M	ALLEGHENY
PETERSON, MD, ARTHUR L	MONTGOMERY
PETERSON, MD, DONALD D	PHILADELPHIA
PETERSON, MD, JUDITH R	PHILADELPHIA
PETERSON, MD, KARL R	BRADFORD
PETERSON, MD, ROGER D	LANCASTER
PETERSON JR, MD, CHARLES B	LANCASTER
PETERSON JR, MD, JAY B	WESTMORELAND
PETERSON-KELLER, MD, SHERYL L	CLINTON
PETICCA, MD, BENJAMIN B	ALLEGHENY
PETILLA, MD, MARIANO E	ALLEGHENY
PETKUS, MD, JOHN A	WAYNE/PIKE
PETRAGLIA, MD, ANGELO A	ALLEGHENY
PETRAGLIA, MD, PAUL	ALLEGHENY
PETRAGLIA, DO, VINCENT F	ALLEGHENY
PETRAS, MD, ADAM F	LACKAWANNA
PETRAUSKI, MD, GARY T	BUCKS
PETRE JR, MD, JOHN H	ERIE
PETRELLA, MD, RICHARD W	ERIE
PETRELLIS, DO, LOUIS D	MONTGOMERY
PETRICCIONE, DO, LISA	PHILADELPHIA
PETRICK, MD, THOMAS P	WESTMORELAND
PETRIDES, MD, ANASTASIA B	DELAWARE
PETRO, MD, DIMITRI M	WASHINGTON
PETRO, KATHLEEN R	STUDENT
PETRONE, MD, LOUIS R	PHILADELPHIA
PETROWSKY, MD, DEBORAH	PHILADELPHIA
PETRUCCELLI, MD, NICHOLAS D	NORTHAMPTON
PETRUCCI, MD, WILLIAM G	PHILADELPHIA
PETRUZZELLI, MD, GUY J	ALLEGHENY
PETT JR, MD, STEPHEN D	ERIE
PETTAPIECE JR, MD, MILTON C	ALLEGHENY
PETTERSON, MD, ERIC	SCHUYLKILL
PETTINATO, MD, SALVATORE R	LACKAWANNA
PETTINELLI, DO, FRANK P	PHILADELPHIA
PETTIT, MD, HORACE	PHILADELPHIA
PETTIT, MD, MARY D	PHILADELPHIA
PETURSSON, MD, SIGURDUR R	ALLEGHENY
PETZ, DO, DARRELL W	ALLEGHENY
PEW IV, MD, JOSEPH N	BERKS
PEZZI, MD, PIO J	MONTGOMERY
PEZZI, MD, THOMAS A	PHILADELPHIA
PEZZONE, MICHAEL A	STUDENT
PEZZUTI, MD, JOHN E	DAUPHIN
PFAEFFLE, MD, HUGO H	ALLEGHENY
PFEFFER, MD, WILLIAM H	PHILADELPHIA
PFEFFER, MD, WILLIAM H	YORK
PFEIFER III, MD, WILLIAM F	LACKAWANNA
PFEIFFER, MD, MILDRED C	PHILADELPHIA
PFEIL, MD, RUSSELL W	LYCOMING
PFISTER, MD, JOHN A	MONTGOMERY
PFISTERER, DAVID A	STUDENT
PFOFF, MD, ROBERT M	WESTMORELAND
PFOHL, MD, DAVID N	PHILADELPHIA
PFRIMMER, MD, WAYNE J	ALLEGHENY
PFROMMER, MD, JAMES H	BUCKS
PFROMMER, MD, JAMES M	PHILADELPHIA
PHADKE, MD, MADHAV V	VENANGO
PHADKE, MD, USHA M	VENANGO
PHADKE, MD, YESHWANT G	INDIANA
PHAM, BAO T	STUDENT
PHAM, HOANGMAI H	STUDENT
PHAM, MD, KIM-THU C	PHILADELPHIA
PHAN, MD, NGOC AN	PHILADELPHIA
PHANSE, MD, KALYANI M	WASHINGTON
PHANSE, MD, MOHAN S	ALLEGHENY
PHARR, MD, TARKTEN A	STUDENT
PHARR, MD, WILLIAM F	MONTOUR
PHATAK, MD, MEENA V	MONTGOMERY
PHEASANT, MD, THOMAS R	DAUPHIN
PHELAN, MD, GERALD R	MONTGOMERY
PHELAN, MD, WILLIAM J	LEHIGH
PHELAN, MD, WILLIAM J	CUMBERLAND
PHELPS, MD, WILLIAM R	ERIE
PHIAMBOLIS, MD, THOMAS P	MONTGOMERY
PHILBIN, MD, JOSEPH F	LACKAWANNA
PHILBIN, MD, TERENCE J	ALLEGHENY
PHILIPS, MD, ANDREW J	PHILADELPHIA
PHILLIPS, MD, CHRISTINE	TIOGA
PHILLIPS, MD, HOWARD T	ALLEGHENY
PHILLIPS, MD, JANE G	ALLEGHENY
PHILLIPS, MD, JOHN C	ALLEGHENY
PHILLIPS, MD, JOHN G	ALLEGHENY
PHILLIPS, MD, PAUL F	DAUPHIN
PHILLIPS, MD, R WAYNE	YORK
PHILLIPS, MD, SPENCER D	LANCASTER
PHILLIPS, MD, THEODORE G	LEHIGH
PHILLIPS, MD, TODD E	TIOGA
PHILLIPS, MD, VERNON R	DAUPHIN
PHILLIPS, MD, WILLIAM A	PHILADELPHIA
PHILLIPS, MD, WILLIAM W	ALLEGHENY
PHILLIPS II, MD, WILLIAM B	PHILADELPHIA
PHILLIPS III, MD, CHESTER A	ALLEGHENY
PHILLIPS III, MD, GORDON R	PHILADELPHIA
PHILLIPS JR, MD, CHESTER A	ALLEGHENY
PHITAYAKORN, MD, CHET	ALLEGHENY
PIACENTE, MD, GREGORY J	PHILADELPHIA
PIASECKI, ANDREW W	STUDENT
PIASIO, MD, MARK A	CLEARFIELD
PIATNEK-LEUNISSEN, MD, DOROTHY A	DELAWARE
PIATT, CLARKE U	STUDENT
PIATT III, MD, JOHN E	CENTRE
PICA, MD, JAMES E	WESTMORELAND
PICARIELLO, MD, MICHAEL A	CHESTER
PICCHIO, MD, LUCIANO A	CUMBERLAND
PICCINI, MD, PAUL A	DAUPHIN
PICCIOTTI, MD, ISABELLA M	ALLEGHENY
PICCONE, DO, BRUCE R	PHILADELPHIA
PICCONE, MD, CAROLYN A	STUDENT
PICCONE, MD, MICHELE R	PHILADELPHIA
PICERNO, NICOLETTE A	STUDENT
PICK, MD, ERNEST J	PHILADELPHIA
PICKAR, MD, JAMES H	DELAWARE
PICKENS, MD, PETER V	MONTGOMERY
PICKERILL, MD, ROBERT G	CAMBRIA
PICKERING, MD, HAROLD C	PHILADELPHIA
PICZON, MD, SEVERINO Y	LACKAWANNA
PIEGARI, MD, GUY N	BERKS
PIEPGRASS, MD, WILLIAM C	LANCASTER
PIERCE, GREG	STUDENT
PIERCE, MD, LESLIE S	WESTMORELAND
PIERCE, MD, RICHARD N	MONTOUR
PIERCE, MD, WILLIAM S	DAUPHIN
PIERDON, MD, STEVEN B	SCHUYLKILL
PIERETTI, DO, MARTIN O	PHILADELPHIA
PIERI, MD, DENEEN A M	PHILADELPHIA
PIEROTTI, MD, RICHARD J	MONTGOMERY
PIEROTTI III, MD, ALDINO L	STUDENT
PIERSON, MD, STEVEN B	BUCKS
PIETRAGALLO, MD, LOUIS D	ALLEGHENY
PIETROPAOLI, MD, ANTHONY P	ALLEGHENY
PIFALO, MD, W BRADLEY	ALLEGHENY
PIFER, MD, GERALD W	ALLEGHENY
PIGEON, RAYMOND G	STUDENT
PIGOZZI, MD, WILLIAM N	ALLEGHENY
PIKE, MD, ANNE H	PHILADELPHIA
PIKE, MD, DEBRA S	BLAIR
PILAREK, MD, VALENTINE F	LUZERNE
PILCHMAN, MD, JEFFREY M	PHILADELPHIA
PILEGGI, MD, ANTHONY J	MONTOUR
PILEK, MD, EUGENE J	BRADFORD
PILEVSKY, NICOLE D	STUDENT
PILEWSKI, MD, JOSEPH M	PHILADELPHIA
PILEWSKI, MD, ROBERT M	VENANGO
PILGRAM, MD, PHILIP A	CLEARFIELD
PILKINGTON, MD, BRYAN G	LEBANON
PILLA, MICHAEL A	STUDENT
PILLAI, MD, PUSHKALAI R	ALLEGHENY
PILMER, MD, SHARON L	PHILADELPHIA
PINK, MD, STUART B	DAUPHIN
PINKERTON, DO, RICHARD A	INDIANA
PINKUS, MD, BARRY O	VENANGO
PINSK, MD, JEFFREY H	DELAWARE
PINSKI, MD, GABRIEL	PHILADELPHIA
PINSKI, MD, JOHN V	YORK
PINTO, MD, ALAN A	BUCKS
PINTO, MD, THOMAS B	ALLEGHENY
PION, DO, JOSEPH A	CUMBERLAND
PIONTEK, MD, CATHERINE M	PHILADELPHIA
PIOTROWSKA, MD, LUCY B	MONTGOMERY
PIPPIDIS, MD, MICHAEL N	DELAWARE
PIRAINO, MD, ANTHONY J	DELAWARE
PIRANIAN, MD, SCOTT S	BUTLER
PIRONE, MD, ARTHUR M	ELK/CAMERON
PIRRELLO JR, MD, ANTHONY M	BUTLER
PIRRIS, MD, JOHN	WASHINGTON
PISANI, MARGARET A	STUDENT
PISARCHICK, JANE M	STUDENT
PISH, MD, RICHARD J	FAYETTE
PISTON, MD, ROBERT W	MERCER
PISTONE, MD, GREGORY A	PHILADELPHIA
PISULA JR, MD, VINCENT P	ADAMS
PISZCZEK, MD, JOSEPH E	LUZERNE
PITCAVAGE, MD, JAMES G	ALLEGHENY
PITCHOK, CARISSA L	STUDENT
PITKOW, MD, RONALD B	BUCKS
PITTENGER, MD, MARY A	PHILADELPHIA
PITTENGER, MD, REX A	ALLEGHENY
PITTS, MD, WILLIAM H	ARMSTRONG
PITUCH, DANIEL W	STUDENT
PITYK JR, MD, PETER E	LEBANON
PIWOZ, MD, SEYMOUR	PHILADELPHIA
PIXLER, MD, MARY G	BERKS
PIZANO, LOUIS R	STUDENT
PIZZANO, MD, JOSEPH A	MONTGOMERY
PIZZI, MD, WILSON B	WASHINGTON
PIZZICA, DO, ALBERT L	PHILADELPHIA
PIZZINI, MARK-ALAN D	STUDENT
PIZZUTILLO, MD, PETER D	PHILADELPHIA
PLACCI, MD, CARLOS A	ALLEGHENY
PLACE, MD, ELMER R	LEBANON
PLAGATA, MD, EDITH M	DELAWARE
PLANO, DO, VINCENT F	NORTHAMPTON
PLASTINO, MD, JOHN E	LANCASTER
PLATKO JR, MD, WILLIAM P	ALLEGHENY
PLATT, MD, BENJAMIN B	SCHUYLKILL
PLATT, MD, DENNIS E	PHILADELPHIA
PLATT, MD, HOWARD A	LACKAWANNA
PLATT, MD, RUTH M	PHILADELPHIA
PLATTO, MD, MICHAEL J	ALLEGHENY
PLESS, MD, PETER R	CRAWFORD
PLETZ, MD, GREGORY J	MONTOUR
PLEWA, MD, MICHAEL C	ALLEGHENY
PLISKIN, MD, MARK	MONROE
PLODKOWSKI, RAYMOND A	STUDENT
PLOTKIN, ADAM S	STUDENT
PLOURDE, MD, PAUL V	LANCASTER
PLOWMAN, MD, JUDITH L	STUDENT
PLUCINSKY, MD, FRANCIS C	BERKS
PLUMB, MD, JAMES D	PHILADELPHIA
PLUMMER, MD, LLOYD G	WESTMORELAND
PLUMMER III, MD, WILLIAM	CHESTER
PLUNDO, DO, GARY P	WESTMORELAND
PLUNDO, DO, LARRY J	WESTMORELAND
PLUNKETT, MD, FRANCIS X	ALLEGHENY
PLUNKETT, MD, MICHAEL B	ALLEGHENY
PLUTNICKI, MD, RONALD S	LANCASTER
PLYMYER, MD, RAY E	BERKS
PO, MD, CHRISTOPHER L	PHILADELPHIA
POBER, MD, HYMEN A	ALLEGHENY
POBER, MD, IREN J	ALLEGHENY
POBER, MD, KENNETH A	INDIANA
POBER, NEIL J	STUDENT
POCHAPIN, MD, SHERMAN W	ALLEGHENY
PODELL, MD, MORRIS J	PHILADELPHIA
PODOLSKY, DO, JOEL	BERKS
PODOLSKY, MD, LEO A	PHILADELPHIA
PODRASKY, MD, DAVID F	BUCKS
POE-ZEIGLER, MD, ROBIN L	YORK
POEHAILOS, MD, KAREN D	LEBANON
POGGI, DO, ALFRED J	SOMERSET
POHL, MD, CHARLES E	LANCASTER

POJE, MD, CHRISTOPHER P	PHILADELPHIA
POKHARNA, MD, MANDAKINI K	ALLEGHENY
POKORNEY, MD, BRUCE H	LANCASTER
POKORNEY, MD, DALE R	MERCER
POLACHECK JR, MD, WILLIAM J	DAUPHIN
POLAKOFF II, MD, PEDRO	PHILADELPHIA
POLAM, MD, CHANDRA R	ALLEGHENY
POLAN, MD, SIMON	PHILADELPHIA
POLASHENSKI, DO, EDWARD S	LUZERNE
POLES, DO, GWENDOLYN A	DAUPHIN
POLEY JR, MD, GERALD E	MONTGOMERY
POLIDORA, MD, FRANK C	LUZERNE
POLIDORA, MD, JOSEPH J	ALLEGHENY
POLIDORI, MD, DAVID J	PHILADELPHIA
POLIN, MD, DAVID G	LANCASTER
POLIN, MD, EDWARD B	PHILADELPHIA
POLINER, MD, HIME S	NORTHAMPTON
POLINSKI, MD, LEONARD J	ALLEGHENY
POLINTAN, MD, RODOLFO S	CLEARFIELD
POLIS, MD, MARK J	LYCOMING
POLISH, MD, BERNARDINE M	MONTGOMERY
POLISHOOK, MD, ROBERT D	PHILADELPHIA
POLISTINA, MD, DEAN C	STUDENT
POLITO, MD, JOSEPH R	CAMBRIA
POLITZER, MD, FRANK E	BERKS
POLK, MD, LEWIS D	PHILADELPHIA
POLK, MD, MIRIAM R	DAUPHIN
POLL, MD, DAVID S	PHILADELPHIA
POLLACK, MD, DOROTHY J	ALLEGHENY
POLLACK, MD, HOWARD M	PHILADELPHIA
POLLACK, MD, MATTHEW S	NORTHAMPTON
POLLER, MD, WILLIAM R	ALLEGHENY
POLLICE, MD, PHILIP G	ALLEGHENY
POLLINO, MD, VINCENT	LACKAWANNA
POLLOCK, MD, ARTHUR E	BLAIR
POLLOCK, MD, BRUCE E	ALLEGHENY
POLLOCK, MD, BRUCE G	ALLEGHENY
POLLOCK, MD, BURTON H	ALLEGHENY
POLLOCK, MD, DENZEL W	MONTGOMERY
POLLOCK, DO, JAMES D	ERIE
POLLOCK, MD, JEFFREY L	PHILADELPHIA
POLLOCK, MD, MICHAEL S	INDIANA
POLMUELLER, MD, EUGENE F	MONTGOMERY
POLSBY, LISA S	STUDENT
POLSKY, MD, HARRY S	MONTGOMERY
POLSTER, MD, SCOTT D	STUDENT
POMERANTZ, DO, BURTON	PHILADELPHIA
POMERANTZ, MD, JOEL D	PHILADELPHIA
POMERANTZ, MD, MARC S	ALLEGHENY
POMERANTZ, MD, PHILIP A	BERKS
POMEROY, MD, JAMES M	DELAWARE
POMMERSHEIM, MD, WILLIAM J	LAWRENCE
POMPER, MD, GREGORY J	STUDENT
POMPONIO, MD, JOSEPH G	NORTHAMPTON
POND, MD, HAROLD S	MONROE
PONTIUS, MD, JOHN G	LANCASTER
PONTZ, BRADFORD S	STUDENT
PONTZ, MD, JACK B	LANCASTER
PONTZER, MD, HERBERT	ELK/CAMERON
PONTZER, MD, PETER F	BLAIR
POOL, MD, CHAMPE C	DAUPHIN
POOLE, MD, EDWARD F	BUCKS
POOLE, MD, ROBERT	CHESTER
POON, EDWARD D	STUDENT
POON, MD, MARIO J	PHILADELPHIA
POORE, MD, GEORGE C	POTTER
POORMAN, MD, S STURGIS	MONTGOMERY
POPAT, MD, ANJANA V	DAUPHIN
POPE, MD, JOHN A	ALLEGHENY
POPE, DO, RONALD L	PHILADELPHIA
POPEY, MD, TRACY L C	STUDENT
POPHAL, MD, MAHLON J	LYCOMING
POPKAVE, MD, ARTHUR H	NORTHAMPTON
POPKY, MD, GEORGE L	PHILADELPHIA
POPLAWSKY, MD, DEBORAH A	MONTOUR
POPOLOW, MD, MICHAEL L	MONTGOMERY
POPORAD, MD, GEORGE A	PHILADELPHIA
POPOVICH, MD, JOHN E	ALLEGHENY
POPPER, MD, DAVID A	BUCKS
PORCELAN, MD, JANE B	DELAWARE
PORGES, MD, STEFANIE B	DELAWARE
PORITSKY, MD, SUSAN	PHILADELPHIA
PORKOLAB, MD, FREDERICK L	ALLEGHENY
PORRECA, MD, GEORGE A	PHILADELPHIA
PORT, MD, J TEIG	LACKAWANNA
PORTER, MD, ALBERT R	DAUPHIN
PORTER, MD, EDGAR L	CHESTER
PORTER, MD, ELIZABETH S	ALLEGHENY
PORTER, MD, MARY M	PHILADELPHIA
PORTER, MD, ROBERT S	CHESTER
PORTER JR, MD, WILLIAM F	LANCASTER
PORTMAN, MD, MARY A	ALLEGHENY
PORTNER, MD, JAY H	PHILADELPHIA
PORTNOY, MD, LARRY NEAL	PHILADELPHIA
PORTNOY, MD, SCOTT L	ALLEGHENY
PORTZ, MD, MATTHEW C	ALLEGHENY
POSATKO, MD, ROBERT J	PHILADELPHIA
POSEY, MD, DALE M	LANCASTER
POSILLICO, MD, LOUIS F	ALLEGHENY
POSNER, DO, MICHAEL H	ADAMS
POSSANZA, MD, CARL J	LACKAWANNA
POST, MD, CHRISTOPHER R	STUDENT
POST, MD, JARVIS H	CAMBRIA
POST, MD, ROBERT M	LEHIGH
POTASH, MD, GEORGE C	LEBANON
POTE JR, MD, HARRY H	CAMBRIA
POTERA, MD, LEO P	LUZERNE
POTKONSKI, MD, LEOPOLD A	BERKS
POTNIS, MD, ASHA V	ALLEGHENY
POTOCHNY, JOHN D	STUDENT
POTORSKI, MD, ROBERT D J	LUZERNE
POTSIC, MD, WILLIAM P	PHILADELPHIA
POTTASH, MD, RUBEN R	PHILADELPHIA
POTTER, ANN L	STUDENT
POTTER, MD, JEFFREY N	DAUPHIN
POTTER, MD, ROBERT H	ALLEGHENY
POTTER JR, MD, HOWARD P	CHESTER
POTTER JR, MD, ROBERT H	ALLEGHENY
POTTS, MD, ASA W	CHESTER
POULIS, MD, DEMETRI T	LYCOMING
POULLIOTT JR, MD, JEROME W	LYCOMING
POULOS, MD, SAVVAS C	BRADFORD
POUTOUS, MD, GEORGE W	ALLEGHENY
POWE, MD, LARRY K	DELAWARE
POWELL, MD, ALVIN P	BUCKS
POWELL, MD, JAMES R	FAYETTE
POWELL JR, MD, OSCAR M	ALLEGHENY
POWELL JR, DO, THOMAS F	PHILADELPHIA
POWER, MD, JOHN A	ALLEGHENY
POWER, DO, THERESA C	DELAWARE
POWERS, MD, BRIAN A	MONROE
POWERS, MD, DONALD V	DELAWARE
POWERS, MD, VICTOR J	LEHIGH
POWERS JR, MD, FRANCIS M	LYCOMING
POZZA, MD, NICHOLAS J	VENANGO
PRABHU, MD, ANIL	ALLEGHENY
PRABHU, MD, NALINA	ALLEGHENY
PRADELL, LAWRENCE	STUDENT
PRADHAN, MD, ANIL G	MCKEAN
PRAGER, MD, DAVID	LEHIGH
PRAKASH, MD, MURTHAPPA N	LUZERNE
PRANCKUN, MD, PETER J	LANCASTER
PRANCKUN, MD, PETER P	LANCASTER
PRASAD, MD, AJIT K	CHESTER
PRASAD, MD, MAHADEVAPPA M	BUTLER
PRASAD, RAINISH	STUDENT
PRASAD, RAJEEV	STUDENT
PRASAD, MD, SHISHIR C	LUZERNE
PRATER, MD, JOHN M	LUZERNE
PRATT, MD, LORETTA A	DELAWARE
PRATT, MD, ROBERT S	LANCASTER
PRAVETZ, MD, MICHAEL J	PHILADELPHIA
PRAWDZIK, MD, LEOCADIA T	LUZERNE
PREATE, MD, DONALD L	LACKAWANNA
PREBOLA, MD, WILLIAM R	PHILADELPHIA
PREGLER, DO, FRANK C	ERIE
PREHATNY, MD, JOHN R	PHILADELPHIA
PREISS, MD, JENNIFER E	ALLEGHENY
PRELI, MD, OLINDO J	LACKAWANNA
PREMAZA-MUELLER, DO, ALICE R	PHILADELPHIA
PRENATT, MD, WILLIAM E	MERCER
PRENDERGAST, MD, MAURICE D	BEAVER
PRENDERGAST, MD, MICHAEL J	YORK
PRENSKY, MD, JAY G	DAUPHIN
PRESPER, MD, JOHN H	LUZERNE
PRESS, MD, ALLAN J	ALLEGHENY
PRESS JR, MD, RICHARD A	BUCKS
PRESSMAN, MD, EDMUND N	CHESTER
PRESSMAN, MD, ROBERT S	PHILADELPHIA
PRESTEL JR, MD, THOMAS F	DELAWARE
PRESTIFILIPPO, MD, ORAZIO	NORTHAMPTON
PRESTIFILPPO, RITA E	STUDENT
PRETTER, MD, PAUL D	ALLEGHENY
PREUCEL, MD, ROBERT W	PHILADELPHIA
PREVOST, MD, JOHN V	TIOGA
PRICE, MD, ALBERT C	LANCASTER
PRICE, MD, ALFRED R	ALLEGHENY
PRICE, MD, EDWIN M	SOMERSET
PRICE, MD, FREDRIC V	ALLEGHENY
PRICE, MD, RAPHAEL I	PHILADELPHIA
PRICE, MD, RICHARD E	CAMBRIA
PRICE, MD, RICHARD T	BUCKS
PRICE, MD, TODD A	BLAIR
PRICE JR, MD, HENRY L	PHILADELPHIA
PRICE JR, MD, JOSEPH J	PHILADELPHIA
PRICE JR, MD, STUART E	ALLEGHENY
PRIDE, MD, HOWARD B	MONTOUR
PRIEST, MD, BRIAN P	PHILADELPHIA
PRIESTLEY, MD, MARGARET A	STUDENT
PRIMIANO, MD, GEORGE A	MONROE
PRIN, MD, WILLIAM	ALLEGHENY
PRIN, MD, WILLIAM A	ADAMS
PRINCE, MD, DOUGLAS H	YORK
PRINCE, MD, LESTER O	ALLEGHENY
PRINCE, MD, RICHARD B	BUCKS
PRINCE, DO, SCOTT S	LUZERNE
PRINCIPATO, DO, ROBERT E	YORK
PRINGLE, MD, JACQUELINE M	ALLEGHENY
PRINGLE, MD, ROBERT W	ALLEGHENY
PRIORE, MD, ROBERT M	ALLEGHENY
PRITT, MD, PAULINE	MONTGOMERY
PROBST, MD, SUSAN J	BERKS
PROCACCI, MD, PASQUALE M	PHILADELPHIA
PROCOPIO, MD, FRANK	DAUPHIN
PROCTOR, MD, JULIAN W	ALLEGHENY
PROCTOR, MARGARET S	STUDENT
PROCTOR, MD, MICHAEL S	WAYNE/PIKE
PROENZA, MD, JOSE L	DELAWARE
PROKHOV, MD, VASSIL K	ALLEGHENY
PROMERSBERGER, MD, MARK E	BRADFORD
PROMISH, MD, DAVID S	PHILADELPHIA
PROMISLOFF, DO, ROBERT A	PHILADELPHIA
PROMUBOL, MD, YUWAREE	WESTMORELAND
PROOTHI, MD, SUBHASH C	LEHIGH
PROPHET, STEVEN A	STUDENT
PROPST, MD, HARRY D	WAYNE/PIKE
PROPST-PROCTOR, MD, SANDRA L	WAYNE/PIKE
PROSHAN, MD, NEIL	PHILADELPHIA
PROSPERI, MD, ALDO J	WESTMORELAND
PROSTKO, MD, E RICHARD	ALLEGHENY
PROUDFIT, MD, J PAUL	WASHINGTON
PROULX, DO, ANNE M	ALLEGHENY
PROVAN, MD, CHARLES A	ALLEGHENY
PROVENCIO, MD, FLORENCIO	LEBANON
PROVENCIO, JAVIER J	STUDENT
PROWELL, MD, JOSEPH W	LANCASTER
PROY, MD, BERNARD C	ERIE
PRUCHNIC, MD, WILLIAM F	CAMBRIA
PRUDENCIO, MD, MARIA E	LEBANON
PRUDENCIO JR, MD, JOSE N	DAUPHIN
PRUITT, MD, JOHN D	MONTGOMERY
PRUSAKOWSKI, DO, JOSEPH M	CLARION
PRYLINSKI, MD, GREGORY V	ERIE
PRYOR JR, MD, CHARLES A	BUCKS
PRZYLEPA, MD, KELLY A	PHILADELPHIA
PTAKOWSKI, MD, GEORGE A	LACKAWANNA
PUBLICKER, MD, MARK R	ALLEGHENY
PUCEVICH, MD, MARIA V	ALLEGHENY
PUEBAN, MD, REYNALDO	WARREN
PUFF, MD, ARTHUR J	PHILADELPHIA
PUFFENBERGER, MD, MARK W	LUZERNE
PUGH, MD, JAMES E	PHILADELPHIA
PUGH, MD, REGINALD P	ALLEGHENY
PUGLIANO, FREDERIC A	STUDENT
PUGLIESE, MD, AUGUST A	ARMSTRONG
PUGLIESE, MD, JOSEPH F	LUZERNE
PUGLIESE, MD, PATRICK D	NORTHUMBERLAND
PUGLISI, MD, ANTHONY S	PHILADELPHIA
PUGLISI, MD, VINCENT	PHILADELPHIA
PUJARA, MD, DEVI M	SCHUYLKILL
PUJARA, MD, MAHENDRA M	SCHUYLKILL
PULITO, MD, JOHN M	CRAWFORD
PULLEKINES, MD, JOSEPH W	ALLEGHENY
PULLEN, MD, HARVEY T	MONROE
PULLMAN-MOGAR, MD, SALLY W	MONTGOMERY
PUMA, MD, SAMUEL J	LUZERNE
PUNDIAK, MD, TERRY J	NORTHAMPTON
PUNUKOLLU, MD, CHANDRAJEKHARA	WESTMORELAND
PUPI, MD, PAUL A	BEAVER
PURCELL, DO, STEPHEN M	LEHIGH
PURCELL JR, MD, ROBERT E	LYCOMING
PURDY, MD, RICHARD T	LANCASTER
PURKAYASTHA, MD, ARINDAM	SUSQUEHANNA
PURNELL, MD, JOHN S	CENTRE
PURNER JR, DO, WILLIAM M	DELAWARE
PURPURA, MD, THOMAS R	ALLEGHENY
PURSELL, MD, ROBERT N	NORTHAMPTON
PURTILL, JAMES J	STUDENT
PUSATERI JR, MD, JOSEPH P	ALLEGHENY
PUSCHAK, MD, RUSSELL B	LEHIGH
PUSHKAREWICZ, MD, MICHAEL J	CHESTER
PUTNAM, MD, MARK A	PHILADELPHIA
PUTNAM, MD, RICHARD C	PHILADELPHIA
PUTPRUSH, MD, JOSEPH R	LUZERNE
PYATT JR, MD, ROBERT S	FRANKLIN
PYFER, MARK F	STUDENT
PYLES, MD, MARK C	COLUMBIA
PYTKO, MD, VALENTINE F	MONTOUR

Q

QUAGLIO, MD, NANNETTE D	MERCER
QUALEY, DEBORAH A	STUDENT
QUALLS, MD, DONALD M	PHILADELPHIA
QUEEN, MD, GEORGE N	ADAMS
QUERCI, DO, JOHN C	LUZERNE
QUERIMIT, MD, JORGE A	LYCOMING
QUEVEDO, MD, JONATHAN P	LEHIGH
QUICKEL, MD, KENNETH E	DAUPHIN
QUIGLEY, MD, MATTHEW R	ALLEGHENY
QUILL, MD, JOSEPH R	MONTGOMERY
QUILO, MD, FELICIDAD F	NORTHAMPTON
QUILO, MD, LINO S	NORTHAMPTON
QUINEY JR, MD, JAMES J	NORTHAMPTON
QUINN, MD, DIANNE M	BUCKS
QUINN, MD, DONN R	NORTHAMPTON
QUINN, MD, GRAHAM E	PHILADELPHIA
QUINN, MD, JOHN R	CAMBRIA
QUINN, DO, PHILIP L	MIFFLIN/JUNI
QUINN, MD, VINCENT J	PHILADELPHIA
QUINN JR, MD, NORMAN J	MONTGOMERY
QUINN JR, MD, THOMAS J	PHILADELPHIA
QUINT, MD, ANDREW R	MONTGOMERY
QUINT, MD, DONALD H	ALLEGHENY
QUINTANA, EILEEN C	STUDENT
QUINTANA, MD, PAULINA G	ALLEGHENY
QUINTERO, MD, MIGUEL J	ALLEGHENY
QUIRK, MD, BRIAN C	DAUPHIN
QUIRK, MD, EDWARD J	MONTGOMERY

R

RAAB, MD, DAVID B	LANCASTER
RAAB, MD, MICHAEL F	NORTHAMPTON
RABER, MD, IRVING M	PHILADELPHIA
RABIN, MD, HAROLD S	DAUPHIN
RABIN, MD, SIDNEY C	CHESTER
RABINOWITZ, MD, HOWARD K	PHILADELPHIA
RABINOWITZ, MD, PHILIP F	ALLEGHENY
RABKIN, MD, MICHAEL S	ALLEGHENY
RABSON, MD, JOSEPH A	MONTGOMERY
RABSON, MD, MOSES	PHILADELPHIA
RACCIATO, MD, PETER J	MONROE
RACE, MD, DAVID F	ERIE
RACH, MD, JOEL F	WASHINGTON
RACHO, MD, GEORGE J	LUZERNE
RACKOW, MD, LAWRENCE L	PHILADELPHIA
RAD, BABAK N	STUDENT
RADBILL, MD, SIDNEY G	PHILADELPHIA
RADECKI, MD, PAULA J	PHILADELPHIA
RADER, MD, MARK D	NORTHAMPTON
RADFAR, MD, FEREYDOON D	ALLEGHENY
RADFAR, MD, NEZAM	ALLEGHENY
RADFAR, MD, ROUHANGIZ H	ALLEGHENY
RADFAR, MD, SORAYA Z	ALLEGHENY
RADICE, MD, EUGENE D	COLUMBIA
RADIN, MD, AUDREY B	PHILADELPHIA
RADIN, MD, E JAMES	BRADFORD
RADKE, MD, JUDITH L	PHILADELPHIA
RADKE, MD, TIMOTHY A	PHILADELPHIA
RADLER, MD, JOHN K	BEAVER
RADON, PAULA A	STUDENT
RADSMA, MD, DOUWE L	ADAMS
RAEZER, MD, DAVID M	DELAWARE
RAFALKO, MD, DAVID M	BEAVER
RAFF, MD, H BARRY	DELAWARE
RAFF, MD, THOMAS C	LANCASTER
RAFFENSPERGER, MD, BRUCE W	PHILADELPHIA
RAFFERTY, DO, MICHAEL F	PHILADELPHIA
RAGONESI, MD, SUSAN S	PHILADELPHIA
RAGOOR, MD, BALAKRISHNA R	WESTMORELAND
RAGOOWANSI, MD, TULSIDAS N	BEAVER
RAHAM, MD, DAVID C	DAUPHIN
RAHAUSER, MD, DAVID M	FRANKLIN
RAHIM, MD, ENAYET	CAMBRIA
RAHMANIAN, MD, NADER	BERKS
RAHNER, MD, RICHARD A	ERIE
RAI, MD, MANDEEP K	LEHIGH
RAIFORD, MD, JOHN W	BUCKS
RAINES, MD, HERBERT S	PHILADELPHIA
RAINES, MD, JONATHAN M	PHILADELPHIA
RAINEY, MD, CYNTHIA L	MONTOUR
RAINEY, MD, EDWARD C	BLAIR
RAINEY, DO, MICHAEL J	LACKAWANNA
RAINVILLE, DO, KAREN L	PHILADELPHIA
RAISCH, MD, FREDERICK J	MERCER
RAIZMAN, MD, RICHARD E	ALLEGHENY
RAJ, MD, STEPHEN S	ERIE
RAJAN, MD, SANDA	CHESTER
RAJASEKHARA, PADMA	STUDENT
RAJASENAN, MD, VASUDEVAN	LAWRENCE
RAJJOUB, MD, RODWAN K	LYCOMING
RAJU, MD, ROBERT N	ALLEGHENY
RAJU, MD, RUDRARAJU P	BLAIR
RAKINIC, MD, JAN	PHILADELPHIA
RAKLEWICZ, MD, MICHAEL C	LUZERNE
RAKOW, DO, JOSEPHINE C M	CUMBERLAND
RALPH, MD, NATHAN	PHILADELPHIA
RALPH, MD, PAMELA J	PHILADELPHIA
RALPH, STEPHANIE P	STUDENT
RALSTON, MD, EDGAR L	PHILADELPHIA
RAM, MD, SANT	ERIE
RAMAGE, MD, ANN L	YORK
RAMAKRISHNA, MD, SRINIVASARAO	LACKAWANNA
RAMAKRISHNAN, MD, THEKKEMADOM P	NORTHAMPTON
RAMALINGAM, MD, SWAMINATHAN	ERIE
RAMAN, MD, ASHA	ALLEGHENY
RAMAN, MD, GITA S	BRADFORD
RAMAN, MD, JAYALAXMI	PHILADELPHIA
RAMANATHAN, MD, RAMESHKUMAR	ALLEGHENY
RAMANUJAM, MD, THAILA	BUCKS
RAMASASTRY, MD, SAI S	ALLEGHENY
RAMBACH, MD, LEONARD	LANCASTER
RAMESH, MD, MAKUM L	ALLEGHENY
RAMIK, MD, OTTO E	ALLEGHENY
RAMINANI, MD, LOKADRI N	MONTGOMERY
RAMIREZ, MD, CONSTANCIO	FRANKLIN
RAMIREZ, MD, RENATO P	CRAWFORD
RAMIREZ, THOMAS B	STUDENT
RAMOS, MD, CLARITA P	WESTMORELAND
RAMS, MD, JAMES J	ALLEGHENY
RAMSEY II, MD, WILLIAM H	MONTGOMERY
RAMSEY JR, MD, HARRY E	BERKS
RANCIER, MD, LEE F	LACKAWANNA
RANCK, MD, SIDNEY G	BRADFORD
RANDALL, MD, J PERLINGIERO	MONTGOMERY
RANDALL, MD, PETER	PHILADELPHIA
RANDALL, MD, RODNEY R	ALLEGHENY
RANDALL IV, MD, ALEXANDER	MONTGOMERY
RANGANATH, MD, GUBBI N	SCHUYLKILL
RANIERI, MD, THOMAS A	WYOMING
RANIERI, MD, TITO A	PHILADELPHIA
RANISH, MD, DEBORAH A	ERIE
RANKIN, DEBRA S	STUDENT
RANKIN, MD, JAMES S	ALLEGHENY
RANKIN, MD, LARRY S	CUMBERLAND
RANKIN, MD, ROBERT C	ALLEGHENY
RANKIN, MD, S GLENN	ALLEGHENY
RANNELS, MD, HERMAN W	LYCOMING
RAO, MD, B VENKAT	ALLEGHENY
RAO, MD, BRINDA E	CHESTER
RAO, MD, KASUGANTI V	ALLEGHENY
RAO, MD, LEELA K	ALLEGHENY
RAO, MD, MADHAVA S	LACKAWANNA
RAO, MD, NALINI	ALLEGHENY
RAO, MD, RAMDEV K	ALLEGHENY
RAO, MD, SUNDER R	ALLEGHENY
RAO, MD, USHA G	YORK
RAO, MD, VIKRAM G	ALLEGHENY
RAO, MD, YASHODA D	SCHUYLKILL
RAPHAEL, MD, PAUL S	LEHIGH
RAPHAEL, MD, STEPHEN A	MONTGOMERY
RAPHAELY, MD, RUSSELL C	PHILADELPHIA
RAPPAPORT, MD, DANIEL M	LEHIGH
RAPPAPORT, MD, ELIZABETH B	MONTGOMERY
RAPPAPORT, MD, LEWIS B	ALLEGHENY

RAPPAPORT, MD, MELVIN M	LEHIGH
RASANSKY, MD, HARRY N	PHILADELPHIA
RASCHID, MD, SOHAEL M	FRANKLIN
RASCOE JR, MD, ROBERT R	PHILADELPHIA
RASHADA, MD, YUSUF A	PHILADELPHIA
RASHID, MD, ABDUL	SCHUYLKILL
RASHKIS, MD, HAROLD A	PHILADELPHIA
RASLEAR, MARIA A	STUDENT
RASO, MD, DOMINIC J	NORTHAMPTON
RASSAI, HAMID R	STUDENT
RATH, MD, GARY A	ALLEGHENY
RATHGEB, MD, JOHN M	WESTMORELAND
RATHORE, MD, DALEEP K	ALLEGHENY
RATINI, DO, ANGELO J	BUCKS
RATKE, MD, HENRY V	LYCOMING
RATNER, MD, LARRY M	BUCKS
RATNER, MD, RICHARD R	DELAWARE
RAU, MD, RAMNATH S	MERCER
RAU, MD, RAYMOND L	ALLEGHENY
RAUB, MD, JAMES A	ALLEGHENY
RAUB, MD, JEFFREY D	VENANGO
RAUBENSTINE, MD, DEBORAH A	CUMBERLAND
RAUCH, MD, DOUGLAS	MERCER
RAVANDOOST, MD, PARVANEH	PHILADELPHIA
RAVANO, MD, JOSE F	ALLEGHENY
RAVANO, MD, PARALUWAN Q	ALLEGHENY
RAVEL, MD, ROBERT L	MONTGOMERY
RAVELLA, MD, SARATH B	LACKAWANNA
RAVES, MD, JOHN J	ALLEGHENY
RAVETZ, DO, ROBERT S	PHILADELPHIA
RAVI, MD, JAN	ALLEGHENY
RAVINDRAN, MD, SRINIVASAN	ALLEGHENY
RAVIOLA, MD, CAROL ANN	PHILADELPHIA
RAVITZ, MD, GERALD A	SCHUYLKILL
RAWA, RANDY S	STUDENT
RAWDIN, DAVID E	STUDENT
RAWNSLEY, MD, HERBERT H	WASHINGTON
RAWSON, MD, HELEN H	MONTGOMERY
RAY, MD, ANNMARIE	BEAVER
RAY, MD, RICHARD L	ALLEGHENY
RAY, MD, TARUN K	PHILADELPHIA
RAYMOND, MD, JOSEPH W	CAMBRIA
RAYMOND JR, MD, FRED D	MONTGOMERY
RAYMUNDO, MD, ROSALINDA R	LAWRENCE
RAYMUNDO III, MD, RICARDO B	LAWRENCE
RAYNAK, MD, FRANK R	MERCER
RAYNER, MD, MARK E	PHILADELPHIA
RAYNES, MD, STANTON M	BUCKS
RAZURI, MD, RAFAEL G	NORTHAMPTON
RAZZINO, MD, RICHARD A	DAUPHIN
REAGAN, MD, MARIE A	ALLEGHENY
REAL, MD, MARK S	CHESTER
REAMS, MD, CARL L	MONTOUR
REARDON JR, MD, PAUL L	WASHINGTON
REBELLO, MD, SUNIL D	BLAIR
REBER, MD, HOWARD F	BERKS
RECALDE, MD, CARLOS M	MIFFLIN/JUNI
RECH, MD, FRANK M	DELAWARE
RECIO, MD, ROLANDO G	ALLEGHENY
RECKER, MD, SCOTT F	BLAIR
RECTOR, MD, ROBERT D	FRANKLIN
RED, MD, DONALD E	DELAWARE
REDA, MD, FRANK A	ALLEGHENY
REDDING, MD, WILLIS A	BRADFORD
REDDY, MD, JAIVEER T	CLARION
REDDY, MD, PATRICIA A	DAUPHIN
REDDY, MD, PUSHPAMALA P	ARMSTRONG
REDDY, MD, RAGOOR K	ALLEGHENY
REDDY, MD, RAJIDI M	LYCOMING
REDDY, SAI S	STUDENT
REDDY, SAPNA S	STUDENT
REDDY, MD, V SARASWATHI	BRADFORD
REDKA, MD, JAMES W	LYCOMING
REDNOR, MD, RONALD P	PHILADELPHIA
REDOVAN, MD, EDWARD G	LAWRENCE
REED, MD, CLIFFORD A	BERKS
REED, MD, CRYSTAL D	PHILADELPHIA
REED, MD, DARRELL K	ALLEGHENY
REED, MD, DAVID M	ALLEGHENY
REED, MD, DAVID T	MONTGOMERY
REED, MD, ELMER M	CENTRE
REED, MD, JANIS E	ALLEGHENY
REED, KRISTYN M	STUDENT
REED, MD, LOLA S	CHESTER
REED, MD, MARK S	BERKS
REED, MD, MICHAEL F	CLEARFIELD
REEDMAN, MD, GAIL A	BUCKS
REEDY, MD, BRIAN K	STUDENT
REEDY, MD, GARY L	LACKAWANNA
REEKIE, MD, TIMOTHY G	PHILADELPHIA
REEL, MD, CHARLES C	ALLEGHENY
REEL, MD, CHARLES M	WESTMORELAND
REES, MD, CHRISTOPHER J	PHILADELPHIA
REES, MD, DAVID B	BERKS
REESE, MD, FRED W	COLUMBIA
REESE, MD, RICHARD W	LANCASTER
REESE, TIMOTHY E	STUDENT
REESE JR, MD, EVAN C	NORTHAMPTON
REEVE, AMANDA D	STUDENT
REEVES, EMILY J	STUDENT
REFOWICH, MD, RICHARD S	NORTHAMPTON
REGALADO, MD, REGULUS D	UNION
REGAN, MD, JAMES R	NORTHAMPTON
REGAN, MD, MARK C	LANCASTER
REGANIS, MD, JOHN C	NORTHAMPTON
REGEC, MD, STEPHEN P	ELK/CAMERON
REGINATO, ANTHONY M	STUDENT
REGUEIRO, MIGUEL D	STUDENT
REHDER, MD, KAREN E	ALLEGHENY
REHR, MD, ROGER B	BERKS
REHRIG JR, SCOTT T	STUDENT
REICH, MD, SYLVIA R	LUZERNE
REICH, MD, WILLIAM P	TIOGA
REICHARD, MD, JAMES L	CENTRE
REICHARD, MD, RICHARD C	BERKS
REICHWEIN, MD, RAYMOND K	DAUPHIN
REID, MD, DANIEL W	DELAWARE
REID, MD, JAMES H	NORTHAMPTON
REIDELL, MD, JOHN S	CENTRE
REIDY, MD, MARGARET E	ALLEGHENY
REIFSNYDER, MD, WILLIAM H	BERKS
REIGART, MD, PAUL M	YORK
REIGEL, MD, DONALD H	ALLEGHENY
REIGH, MD, ERNEST E	BERKS
REILEY, DO, MARGARET A	BERKS
REILLY, MD, ANN E	CHESTER
REILLY, MD, CHARLES M	YORK
REILLY, MD, DESMOND J	DAUPHIN
REILLY, MD, JAMES J	ALLEGHENY
REILLY, MD, JOHN C	ERIE
REILLY, MD, JUSTINE M	ERIE
REILLY, MD, MARTHA M	MONTGOMERY
REILLY, MD, MICHAEL J	FAYETTE
REILLY, MD, PAUL A	ALLEGHENY
REILLY, MD, PHILLIP E	FAYETTE
REILLY, DO, ROBERT E	BUCKS
REILLY, MD, THOMAS M	PHILADELPHIA
REILLY JR, MD, JAMES J	ALLEGHENY
REILLY JR, MD, PHILIP J	WESTMORELAND
REIMER, MD, CRAIG L	SCHUYLKILL
REINA, MD, CHARLES R	NORTHAMPTON
REINACH, ALAN J	STUDENT
REINBOLD, PAUL M	STUDENT
REINECKE, MD, ROBERT D	PHILADELPHIA
REINER, MD, BRUCE I	CLEARFIELD
REINER, MD, REBECCA L	BERKS
REINHARD, MD, DAVID L	PHILADELPHIA
REINHARD, MD, HAROLD J	WARREN
REINHARD, MD, RONALD J	YORK
REINHARDT, MD, PAULINE K	LEHIGH
REINHART, MD, JOHN W	LEHIGH
REINHART JR, MD, RAYMOND B	BUCKS
REINMUTH, MD, OSCAR M	ALLEGHENY
REINPRECHT, MD, JAMES T	PHILADELPHIA
REINSEL, MD, RICHARD C	BERKS
REIS, MD, CLAUDE J	ALLEGHENY
REIS, MD, GREGG J	PHILADELPHIA
REIS, MD, PAUL B	LYCOMING
REIS, MD, WALTER J	ALLEGHENY
REISER, MD, HARVEY J	LUZERNE
REISH, MD, WILLIAM G	UNION
REISINGER, MD, SUSAN A	PHILADELPHIA
REISINGER JR, MD, WILLIAM E	SOMERSET
REISS III, G RUSSELL	STUDENT
REISS JR, MD, G RUSSELL	MONTGOMERY
REITANO JR, MD, JOSEPH F	DELAWARE
REITER, MD, DAVID	PHILADELPHIA
REITER, GEORGE T	STUDENT
REITKNECHT, MD, FELICE L	BRADFORD
REITSMA, MD, DOUGLAS B	DELAWARE
REITZ, MD, MARYELLEN	ERIE
REITZ, MD, MELVIN L	SCHUYLKILL
RELIGIOSO, MD, ELOISA P	WESTMORELAND
RELTON, MD, SUDHAKAR C	ALLEGHENY
RELUZ, MD, JAVIER S	MONTGOMERY
REMALY, MD, DONALD A	COLUMBIA
REMICK, DO, PAUL F	LACKAWANNA
RENDIN, MD, LARRY J	DELAWARE
RENINGER, MD, CHARLES W	LEHIGH
RENKERT, MD, ELIZABETH E	BERKS
RENNINGER, EXEC SEC, RHONDA	YORK
RENO, MD, JOSEPH D	DELAWARE
RENSIMER, MD, WAYNE T	BRADFORD
RENTLER, MD, RUSSELL J	LEHIGH
RENTON, MD, ALAN C	ALLEGHENY
RENZ, MD, ROBERT T	ERIE
REPPERT, MD, WILLIAM D	NORTHAMPTON
RESCINITI, MD, MARK A	ADAMS
RESHMI, MD, CHANDRAPPA S	ALLEGHENY
RESNICK, MD, ALBERT B	PHILADELPHIA
RESNICK, MD, DANIEL K	PHILADELPHIA
RESNICK, MD, EDWARD J	PHILADELPHIA
RESNICK, MD, GEORGE J	PHILADELPHIA
RESNICK, MD, MYRON E	DELAWARE
RESNICK, MD, PAUL H	ALLEGHENY
RESNICK, PETER F	STUDENT
RESNIK, MD, ALAN M	PHILADELPHIA
RESPET, MD, PATRICK B	LEHIGH
RESTREPO, MD, JAMES P	BERKS
RESURRECCION, MD, ROSARIO	PHILADELPHIA
RETTIG, MD, STEPHEN J	FRANKLIN
RETTIG III, LLOYD W	STUDENT
REUBEN, MD, MARK S	BERKS
REUSCHE III, DO, FRANK L	ERIE
REVAK, MD, BLAIRANNE H	COLUMBIA
REVAK, DO, DAVID J	COLUMBIA
REX, MD, JAMES C	LEHIGH
REYES, MD, PATRICIO F	PHILADELPHIA
REYES, MD, SATURNINO M	BEAVER
REYES, MD, VICENTE E	ALLEGHENY
REYNA, MD, OSCAR D	WESTMORELAND
REYNER, MD, HOPE A	LEBANON
REYNOLDS, MD, CHRISTOPHER R	BUCKS
REYNOLDS, MD, HERBERT Y	DAUPHIN
REYNOLDS, MD, LYNNE M	PHILADELPHIA
REYNOLDS, DO, WAYNE J	NORTHAMPTON
REYNOSO, MD, ZORAIDA L	PHILADELPHIA
REZAIAN, MD, MICHAEL M	PHILADELPHIA
REZEK, MD, DONALD L	ALLEGHENY
REZNAK, MD, STEPHEN E	PHILADELPHIA
REZNICK, MD, BARRY R	BEAVER
RHEE, MD, EDWARD K	STUDENT
RHEE, MD, SOUNGOK	PHILADELPHIA
RHIEW, MD, FRANCIS C	LACKAWANNA
RHIEW, RICHARD C	STUDENT
RHOAD, ROBERT C	STUDENT
RHOADES, DO, DENNIS W	JEFFERSON
RHOADS, MD, DONALD V	PHILADELPHIA
RHOADS, DONELLE L	STUDENT
RHOADS, MD, HARRY M	CAMBRIA
RHOADS JR, MD, JONATHAN E	YORK
RHOADS SR, MD, JONATHAN E	PHILADELPHIA
RHODE, MD, MARVIN C	MONTGOMERY
RHODES, MD, ARTHUR R	ALLEGHENY
RHODES, DONALD R	STUDENT
RHODES, MD, JEFFREY M	DAUPHIN
RHODES, MD, MICHAEL	LEHIGH
RHODES, MD, ROBERT A	DELAWARE
RHODES III, MD, LUTHER V	LEHIGH
RHOOD, MD, SAMUEL G	DELAWARE
RIAL, MD, WILLIAM Y	DELAWARE
RIBAUDO, MD, JANICE	WESTMORELAND
RIBEN, MICHAEL W	STUDENT
RICCELLI, MD, ANTONIO M	ALLEGHENY
RICCHETTI, MD, ROBERT J	PHILADELPHIA
RICCHIUTI, MD, A GEORGE	SCHUYLKILL
RICCHIUTI, MD, JOSEPH F	SCHUYLKILL
RICCI, ANTHONY N	STUDENT
RICCI, MD, JOSEPH A	DAUPHIN
RICCIUTI, MD, ALEXANDER J	PHILADELPHIA
RICE, MD, DONALD H	BLAIR
RICE, MD, EILEEN M	ALLEGHENY
RICE, MD, GEORGE E	PHILADELPHIA
RICE, NATALIE M	STUDENT
RICE, MD, PATRICK D	BLAIR
RICE, MD, SAMUEL A	LANCASTER
RICE, MD, SAMUEL M	ALLEGHENY
RICE III, MD, JOHN E	MONTOUR
RICH, MD, DEAN C	MONTGOMERY
RICH, MD, JAMES F	DAUPHIN
RICHARD, MD, DAVID C	ALLEGHENY
RICHARDS, MD, ANDREW J	DAUPHIN
RICHARDS, MD, CHARLES H	ALLEGHENY
RICHARDS, MD, CYNTHIA H	DELAWARE
RICHARDS, MD, HENRY M	MONTGOMERY
RICHARDS, MD, JOHN C	BUCKS
RICHARDS, MD, ROBERT N	FRANKLIN
RICHARDS JR, MD, ROBERT N	FRANKLIN
RICHARDSON, MD, DAVID W	PHILADELPHIA
RICHARDSON, MD, GEORGE A	PHILADELPHIA
RICHARDSON, MD, GEORGE S	ALLEGHENY
RICHARDSON, MD, HARRISON H	BEAVER
RICHARDSON, MD, JAMES E	WASHINGTON
RICHARDSON, MARIE P	STUDENT
RICHARDSON, MD, PAUL A	PHILADELPHIA
RICHEY, MD, JAMES E	CAMBRIA
RICHIE, MD, A THOMAS	BUCKS
RICHMAN, MD, CRAIG G	PHILADELPHIA
RICHMAN, MD, KENNETH A	PHILADELPHIA
RICHMAN, MD, MORTON W	MONTGOMERY
RICHMAN, MD, TOBI B	ERIE
RICHMOND, MD, ALLEN C	PHILADELPHIA
RICHMOND, MD, SPENCER I	MONTGOMERY
RICHTER, MD, HOWARD A	DELAWARE
RICHTER, MD, MELVYN P	MONTGOMERY
RICHTER, MD, PAUL L	ALLEGHENY
RICHTERMAN, MD, IRA E	PHILADELPHIA
RICKELS, MD, KARL	PHILADELPHIA
RICKLOFF, MD, RAYMOND J	ERIE
RICKS, MD, JOHN E	CUMBERLAND
RICOTTA, CHARLOTTE	STUDENT
RICTOR, MD, KENNETH W	FRANKLIN
RIDELLA, MD, PETER J	CAMBRIA
RIDEN, MD, ALICE E	LANCASTER
RIDER, JILL A	STUDENT
RIDER-FOSTER, MD, DAWN M	PHILADELPHIA
RIDGWAY, MD, WILLIAM G	LANCASTER
RIDOUT III, MD, DANIEL L	PHILADELPHIA
RIEMER, MD, BARRY L	ALLEGHENY
RIENZI, MD, JOSEPH P	LACKAWANNA
RIENZO, MD, ROBERT J	LEHIGH
RIETHER, MD, ROBERT D	LEHIGH
RIETHMILLER, MD, GRACE L	ALLEGHENY
RIFE, MD, CHARLES J	DAUPHIN
RIFFERT, MD, PAUL M	LANCASTER
RIFKIN, MD, MICHAEL H	ALLEGHENY
RIGANO JR, MD, RUDOLPH F	LANCASTER
RIGG, MD, L ISOBEL	PHILADELPHIA
RIGGLEMAN, MD, MICHAEL P	DAUPHIN
RIGGS, MD, RICHARD V	PHILADELPHIA
RIGHTMYER, MD, JOHN N	BERKS
RIGHTOR, MD, JOHN T	VENANGO
RIGHTS, MD, THEODORE H	BERKS
RIGNEY JR, MD, JAMES H	BUCKS
RIGOTTI, DO, JOSEPH A	MONTGOMERY
RIKE, MD, PAUL M	ALLEGHENY
RILEY, MD, BERNARD J	ALLEGHENY
RILEY, MD, JUDITH A	PHILADELPHIA
RILEY, PAT	STUDENT
RILEY, MD, VERYL M	WARREN
RILLING, MD, DAVID C	BUCKS
RIM, MD, ALICE S	ALLEGHENY
RIM, MD, JEUNG K	LEBANON
RIMPLE, MD, DAVID F	LUZERNE
RINARD, MD, GRAFFIOUS L	BEDFORD
RINCK II, MD, GEORGE W	UNION
RING, MD, ILONA R	DELAWARE
RINGAWA, MD, PETER E	COLUMBIA
RINGIEWICZ, MD, PAUL A	DELAWARE
RINGLER JR, MD, HAROLD L	CAMBRIA
RINGOLD, MICHAEL A	STUDENT
RINGOLD, MD, MURRAY H	BUCKS
RINKER, MD, R JAMES	YORK
RINKOFF, MD, JEFFREY S	ALLEGHENY
RIOFSKI, MD, ANTHONY F	LUZERNE
RIPEPI, MD, ANTHONY C	ALLEGHENY
RIPEPI, MD, JENNIFER K	ALLEGHENY
RIPEPI, MD, PHILIP P	ALLEGHENY
RIPPLE, MD, PAUL H	LANCASTER
RISING, MD, DAVID C	BUCKS
RISLEY III, WALTER P	STUDENT
RISMILLER, MD, ROSS W	SCHUYLKILL
RITCHIE, MD, CHARLES A	DELAWARE
RITCHIE, MD, DAVID J	PHILADELPHIA
RITCHIE, MD, LAURENCE T	ALLEGHENY
RITCHIE, MD, MARIANNE T	DELAWARE
RITCHIE III, MD, JOHN C	PHILADELPHIA
RITSEMA, MD, RITA L	DELAWARE
RITTENBERG, MD, MICHAEL H	LUZERNE
RITTENHOUSE, MD, EMORY A	ALLEGHENY
RITTENHOUSE, MD, ERIC R	YORK
RITTENHOUSE, MD, FRANK H	ALLEGHENY
RITTENHOUSE, MD, JEFFREY B	LANCASTER
RITTER, MD, AMOS	ALLEGHENY
RITTER, MD, CHARLES W	PHILADELPHIA
RITTER, MD, DEBORAH E	PHILADELPHIA
RITTER, MD, THOMAS J	SCHUYLKILL
RIVARD, MD, JOHN M	PHILADELPHIA
RIVAS, MD, DAVID A	MONTGOMERY
RIVAS-FLORES JR, MD, AURELIANO	MONTGOMERY
RIVERA, MD, EDMUNDO I	PHILADELPHIA
RIVERA, MD, EDWIN A	YORK
RIVERA, MD, JOSE L	NORTHAMPTON
RIVERA, MD, MARIA-JOSEFINA	DELAWARE
RIVERA, MD, VICTOR C	BUCKS
RIVERA-RODRIGUEZ, MD, GABRIEL	JEFFERSON
RIVIELLO, RALPH J	STUDENT
RIXEY, MD, CHARLES O	MONTOUR
RIZK, MD, PAMELA J	ALLEGHENY
RIZZO, MD, JOHN S	DELAWARE
RIZZO, MD, KAREN A	LANCASTER
RIZZOLO, MD, STEVEN J	PHILADELPHIA
ROACHE, MD, MARTIN J	CHESTER
ROAT, MD, MELVIN I	ALLEGHENY
ROBA, MD, LAURIE A	ALLEGHENY
ROBB, MD, MARIE E	NORTHAMPTON
ROBBINS, MD, ELIZABETH L	PHILADELPHIA
ROBBINS, MD, HOWARD S	LANCASTER
ROBBINS, MD, INGA H	PHILADELPHIA
ROBBINS, MD, MARK S	PHILADELPHIA
ROBBINS, MD, ROBERT	PHILADELPHIA
ROBBINS, DO, SUSAN E	ERIE
ROBBINS, MD, WARREN J	LANCASTER
ROBBINS, MD, WILLIAM S	PHILADELPHIA
ROBERTELLO, MD, WILLIAM JOHN	PHILADELPHIA
ROBERTI, MD, NICHOLAS E	JEFFERSON
ROBERTS, MD, ANDREW S	PHILADELPHIA
ROBERTS, MD, BROOKE	PHILADELPHIA
ROBERTS, DEBORAH L	STUDENT
ROBERTS, MD, HASKELL E	LANCASTER
ROBERTS, MD, JOAN M	PHILADELPHIA
ROBERTS, MD, JOHN H	CHESTER
ROBERTS, MD, JOHN M	PHILADELPHIA
ROBERTS, MD, LENORE B	MONTGOMERY
ROBERTS, DO, ROBERT L	YORK
ROBERTS, MD, STEVEN A	PHILADELPHIA
ROBERTS JR, MD, PHILIP G	CENTRE
ROBERTSON, MD, JAMES F	MONTGOMERY
ROBERTSON, MD, JOHN J	BERKS
ROBERTSON, MD, JOHN L	WARREN
ROBERTSON, MD, JOHN W	PHILADELPHIA
ROBERTSON, MD, ROGER J	FRANKLIN
ROBERTSON-SCHEIER, CRISTY A	STUDENT
ROBINSON, MD, CLAIRE E B	PHILADELPHIA
ROBINSON, ELIZABETH L	STUDENT
ROBINSON, MD, FREDERICK A	PHILADELPHIA
ROBINSON, MD, JAMES A	YORK
ROBINSON, MD, JAY A	BLAIR
ROBINSON, MD, JOHN N	ALLEGHENY
ROBINSON, MD, JOSEPH	LUZERNE
ROBINSON, MD, LESLIE E	YORK
ROBINSON, MD, MICHAEL L	BUCKS
ROBINSON, MD, MICHAEL L	BERKS
ROBINSON, MD, MURRAY D	LEHIGH
ROBINSON, MD, NATHANIEL M	PHILADELPHIA
ROBINSON II, MD, GEORGE R	YORK
ROBINSON JR, MD, ELLIOTT S	BRADFORD
ROBINSON JR, MD, JAMES J	PHILADELPHIA
ROBINSON JR, MD, WARREN L	LYCOMING
ROBISON, DO, CAROL K	CUMBERLAND
ROBISON, MD, ELIZABETH A	CHESTER
ROBISON, MD, ROBERT N	DAUPHIN
ROBISON, DO, TERRY A	CUMBERLAND
ROBISON, MD, WALTER J	ALLEGHENY
ROBY, MD, DAVID S	PHILADELPHIA
ROCCARIO, DO, DANTE S	DELAWARE
ROCCO, JACK F	STUDENT
ROCCO, MD, MARTIN J	PHILADELPHIA
ROCCO, MD, NICHOLAS J	PHILADELPHIA
ROCHE, MD, KAREN R	ALLEGHENY
ROCHE JR, MD, EDWARD J	MCKEAN
ROCHMAN, MD, ALAN J	DAUPHIN
ROCK, MD, ELIZABETH D	CHESTER
ROCK, MD, IRA M	ALLEGHENY
ROCK, MD, JAMES A	CAMBRIA
ROCK, MD, LEONARD L	SOMERSET
ROCKOWER, MD, ROGER A	CENTRE
RODA, DO, DAVID M	LANCASTER
RODA, MD, PAUL I	LUZERNE
RODENBERGER, MD, BRUCE M	LEHIGH

RODGERS, MD, CARLA PHILADELPHIA
RODGERS, MD, CHARLES J LYCOMING
RODGERS, MD, DAVID M PHILADELPHIA
RODGERS, MD, FLORENCE E PHILADELPHIA
RODGERS, MD, JOSEPH F PHILADELPHIA
RODGERS, MARK S STUDENT
RODGERS, MD, TIMOTHY J PHILADELPHIA
RODGERS III, MD, WILLIAM H MONTGOMERY
RODRIGO, MD, CONCEPCION V LUZERNE
RODRIGUEZ, MD, ADOLFO E BERKS
RODRIGUEZ, ALEJANDRO STUDENT
RODRIGUEZ, MD, ALFONSO LUZERNE
RODRIGUEZ, MD, DAISY A PHILADELPHIA
RODRIGUEZ, MD, EDSEL A NORTHUMBERLAND
RODRIGUEZ, MD, GEORGE L PHILADELPHIA
RODRIGUEZ, MD, HUGO F DELAWARE
RODRIGUEZ, MD, JULIO A BLAIR
RODRIGUEZ, MD, NORBERTO A ALLEGHENY
RODRIGUEZ, MD, RAYMOND PHILADELPHIA
RODRIGUEZ, MD, RODOLFO E DAUPHIN
RODRIGUEZ, MD, VICTOR R NORTHAMPTON
RODRIGUEZ-FEO, MD, RAUL CAMBRIA
ROE, MD, EUGENE J LACKAWANNA
ROE, MD, HANS S CUMBERLAND
ROE, MD, ROBERT E LUZERNE
ROEDDER, MD, SUSAN L PHILADELPHIA
ROEDER, MD, DONALD K CUMBERLAND
ROEDER, MD, KATHLEEN M BUCKS
ROEDIGER, MD, PAUL M MONTGOMERY
ROESER, MD, MINDI M PHILADELPHIA
ROESHOT, MD, DOUGLAS E CENTRE
ROFSKY, MD, HOWARD E CHESTER
ROGAL, MD, MICHAEL J ALLEGHENY
ROGALLA, MD, CHARLES S LACKAWANNA
ROGERS, MD, ALBERT K LANCASTER
ROGERS, MD, CLINTON L SOMERSET
ROGERS, MD, GEORGE E CAMBRIA
ROGERS, MD, HUGH J CENTRE
ROGERS, MD, JAMES F PHILADELPHIA
ROGERS, DO, JEFFREY S LEHIGH
ROGERS, MD, JOHN F NORTHAMPTON
ROGERS, MD, JONATHAN J MONTGOMERY
ROGERS, MD, KENNETH J CENTRE
ROGERS, MD, PAUL H CHESTER
ROGERS, MD, R CLAUDE PHILADELPHIA
ROGERS, MD, STEVEN ALLEGHENY
ROGERS, MD, VINCENT P ERIE
ROGERS JR, MD, ROBERT M BERKS
ROGERSON, MD, DAVID R CAMBRIA
ROGEVICH, DO, JOSEPH E LANCASTER
ROGINA, DO, LAWRENCE E FRANKLIN
ROGOVITZ, MD, DAVID M SCHUYLKILL
ROGOW, MD, EDWARD ALLEGHENY
ROGOWSKI, MD, RAYMOND A CHESTER
ROHATGI, MD, ANITA NORTHAMPTON
ROHATGI, MD, CHAND NORTHAMPTON
ROHATGI, MD, RAJEEV NORTHAMPTON
ROHLAND, MD, DONALD V DAUPHIN
ROHNER JR, MD, THOMAS J DAUPHIN
ROHR, MD, ALBERT S MONTGOMERY
ROHRABAUGH JR, MD, CHARLES M DAUPHIN
ROHRBECK, MD, CHARLES W CENTRE
ROHRER, MD, G VICTOR DAUPHIN
ROIG, MD, GEORGE M ALLEGHENY
ROITMAN, MD, GABRIELA M PHILADELPHIA
ROITMAN, MD, HARRY B PHILADELPHIA
ROITMAN, MD, SUSAN CHESTER
ROJAS, MD, JOB F PHILADELPHIA
ROJAS, MD, JULIO R LUZERNE
ROJER, MD, CHARLES L MONTGOMERY
ROLLE JR, MD, WILLIAM A PHILADELPHIA
ROLLO, MD, DANIEL P LEBANON
ROMAGOSA, MD, ANGELO E ALLEGHENY
ROMAN, MD, LAURIAN PHILADELPHIA
ROMAN, MD, NANCY V PHILADELPHIA
ROMAN, MD, STEPHEN J WESTMORELAND
ROMANELLI, MD, MICHAEL F PHILADELPHIA
ROMANIC, MD, BRUCE M COLUMBIA
ROMANO, MD, JANET E PHILADELPHIA
ROMANO, MD, JOSEPH M ALLEGHENY
ROMANO, MD, VINCENT E BUCKS
ROMANO JR, MD, MICHAEL T BUCKS
ROMANO-JANA, MD, LOURDES R ERIE
ROMANOFF, MD, DAVID PHILADELPHIA
ROMANOW, MD, PETER W PHILADELPHIA
ROMANZO, MD, GEORGE M MONTGOMERY
ROMBERGER JR, MD, JAMES A ALLEGHENY
ROMEIKA, MD, MARY M SCHUYLKILL
ROMEO, MD, BRUNO J CUMBERLAND
ROMEO, RYAN C STUDENT
ROMEO, MD, VICTORIA J CLINTON
ROMINGER, MD, C JULES CHESTER
ROMM, MD, DANIEL S DAUPHIN
ROMMEL, MD, CATHERINE T LANCASTER
ROMMEL, MD, F MICHAEL LANCASTER
ROMMEL, MD, VICTORIA BEAVER
ROMY, MD, MAURICE PHILADELPHIA
RONEY, MD, T JAMES ALLEGHENY
RONGAUS, MD, WILLIAM J WASHINGTON
RONIS, MD, MAX L PHILADELPHIA
RONNERMANN, MD, DREW P MONTGOMERY
ROODE, MD, ALBERT G VENANGO
ROODE, MD, PHILIP J VENANGO
ROOKLIN, MD, ANTHONY R DELAWARE
ROONEY, MD, DAVID G CHESTER
ROONEY, MD, JOSEPH W BEAVER
ROOS, MD, ALFRED T ERIE
ROOS, DO, EUGENE H BUCKS
ROOS, MD, LEON ADAMS
ROOT, MD, DOUGLAS C SOMERSET
ROPPOLO, MD, HELEN M ALLEGHENY
ROQUIZ, MD, ELISEO M ERIE
RORICK, MD, NICHOLAS R MONTGOMERY
RORKE III, MD, JOHN H CHESTER
ROS, MD, EMIL J ALLEGHENY
ROSA, MD, DEBORAH M CHESTER
ROSA, MD, RAMON A PHILADELPHIA
ROSALES, MD, GABRIEL B BUCKS
ROSALES, MD, MARY T O ALLEGHENY
ROSAN, DO, JAY R MONTGOMERY
ROSAN, DO, STUART W BUCKS
ROSARIO JR, MD, ELISEO CUMBERLAND
ROSARIO-LEON, MD, NELSON R YORK
ROSATO, MD, DONALD J CHESTER
ROSATO, MD, ERNEST F PHILADELPHIA
ROSATO, MD, ERNEST L PHILADELPHIA
ROSATO, MD, FRANCIS E PHILADELPHIA
ROSCH, MD, JULIUS C BLAIR
ROSCHEL, MD, ROBERT L LANCASTER
ROSCOE, MD, CONSTANTINE PHILADELPHIA
ROSCOE, MD, GREGORY J JEFFERSON
ROSE, MD, CAROL E ALLEGHENY
ROSE, MD, DAVID MONTGOMERY
ROSE, DOUGLAS J STUDENT
ROSE, MD, ELIZABETH K PHILADELPHIA
ROSE, MD, FREDERICK S BRADFORD
ROSE, MD, GILBERT M DELAWARE
ROSE, MD, HENRY S PHILADELPHIA
ROSE, MD, JOEL E DAUPHIN
ROSE, MD, JOHN F MONTOUR
ROSE, KIMBERLY A STUDENT
ROSE, MD, LESLIE I PHILADELPHIA
ROSE, MD, LEWIS J PHILADELPHIA
ROSE, MD, ROBERT M MONTGOMERY
ROSEFSKY, MD, JONATHAN B MONTGOMERY
ROSEMAN, MD, RICHARD L DELAWARE
ROSEMOND, MD, GEORGE P PHILADELPHIA
ROSEN, MD, BRUCE J DELAWARE
ROSEN, MD, DANIEL H VENANGO
ROSEN, MD, DAVID PHILADELPHIA
ROSEN, ILENE M STUDENT
ROSEN, MD, JOHN N BUCKS
ROSEN, MD, JOSEPH H PHILADELPHIA
ROSEN, MD, LEONARD DELAWARE
ROSEN, MD, LESTER LEHIGH
ROSEN, MD, MARC R PHILADELPHIA
ROSEN, MD, MARVIN I PHILADELPHIA
ROSEN, MD, RANDY A LEHIGH
ROSEN, MD, RHODA PHILADELPHIA
ROSENAU, DO, ALEXANDER M LEHIGH
ROSENBACH, MD, LOREN M ALLEGHENY
ROSENBAUM, MD, ARMAND L PHILADELPHIA
ROSENBAUM, MD, ARON CAMBRIA
ROSENBAUM, MD, CARL A PHILADELPHIA
ROSENBAUM, GLEN E STUDENT
ROSENBAUM, MD, JOEL N PHILADELPHIA
ROSENBAUM JR, MD, LEON PHILADELPHIA
ROSENBERG, MD, FRANK DELAWARE
ROSENBERG, MD, HENRY PHILADELPHIA
ROSENBERG, MD, HOWARD D LEHIGH
ROSENBERG, MD, IRVING PHILADELPHIA
ROSENBERG, MD, JENNIFER T ALLEGHENY
ROSENBERG, MD, KENNETH C PHILADELPHIA
ROSENBERG, MD, LAWRENCE S CAMBRIA
ROSENBERG, MD, MANUEL PHILADELPHIA
ROSENBERG, MD, PAUL E PHILADELPHIA
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ROSENBERG, MD, RANDY M PHILADELPHIA
ROSENBERG, MD, ROBIN E PHILADELPHIA
ROSENBLATT, MD, STANLEY A LUZERNE
ROSENBLATT, MD, STANLEY G CAMBRIA
ROSENBLOOM, MD, MEYER A ALLEGHENY
ROSENBLOOM, MD, RICHARD C ALLEGHENY
ROSENBLOOM, MD, STANLEY E ALLEGHENY
ROSENBLUM, MD, FRANCES L MONTGOMERY
ROSENBLUM, MD, FRED A MONTGOMERY
ROSENBLUM, MD, MINDY F PHILADELPHIA
ROSENBLUM, MD, NORMAN G PHILADELPHIA
ROSENCRANS, MD, DAVID L ALLEGHENY
ROSENCRANTZ, MD, ELLIOT BLAIR
ROSENFELD, MD, BERNARD D LACKAWANNA
ROSENFELD, MD, DAVID J LANCASTER
ROSENFELD, MD, JACK C MONTGOMERY
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ROSENFELD, MD, PHILIP A MONTGOMERY
ROSENFELD, MD, RICHARD N MONTGOMERY
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ROSENMAN, MD, HOWARD D BUCKS
ROSENN, MD, MARC F MONTGOMERY
ROSENOW JR, MD, EDWARD C PHILADELPHIA
ROSENSTOCK, RACHEL J STUDENT
ROSENSWEIG, MD, WILLIAM LUZERNE
ROSENTHAL, MD, DAVID E PHILADELPHIA
ROSENTHAL, MD, MARK E MONTGOMERY
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ROSENTHAL, MD, STEPHEN I LACKAWANNA
ROSENWASSER, MD, ROBERT HILLEL PHILADELPHIA
ROSENZWEIG, MD, ANDREW S ALLEGHENY
ROSENZWEIG, MD, MARTIN H PHILADELPHIA
ROSENZWEIG, MD, MAX PHILADELPHIA
ROSENZWEIG, MD, SETH E BERKS
ROSIECKI, MD, MICHAEL W LACKAWANNA
ROSKA, MD, JOSE C COLUMBIA
ROSKIN, ROBERT E STUDENT
ROSKO, MD, THOMAS J BUCKS
ROSKOS, STEVEN E STUDENT
ROSNER, MD, ISADOR K PHILADELPHIA
ROSNER, MD, MICHAEL J MONTGOMERY
ROSS, MD, ABRAHAM LEHIGH
ROSS, MD, D GWENDOLYN ALLEGHENY
ROSS, MD, DANIEL I LEHIGH
ROSS, DAVID S STUDENT
ROSS, MD, DENISE H PHILADELPHIA
ROSS, MD, GARY W LACKAWANNA
ROSS, MD, HELEN L MONTOUR
ROSS, MD, PATRICIA E CHESTER
ROSS, MD, R DOUGLAS PHILADELPHIA
ROSS, MD, VINCENT L LACKAWANNA
ROSS, MD, WILLIAM M BUCKS
ROSS III, MD, ARTHUR J PHILADELPHIA
ROSSI, MD, JOHN A DAUPHIN
ROSSI, MD, JOHN C ALLEGHENY
ROSSI, MD, MICHAEL A LEHIGH
ROSSI, MD, MICHELLE I ALLEGHENY
ROSSI JR, MD, RALPH A CHESTER
ROSSMAN, MD, MAX LEHIGH
ROSSMAN, MD, RONALD E PHILADELPHIA
ROST, MD, CHARLES R LANCASTER
ROST, MD, KAY S WESTMORELAND
ROSTOCK, MD, ROBERT A LUZERNE
ROSVANIS, MD, THOMAS K ALLEGHENY
ROTENBERG, MD, LARRY A BERKS
ROTH, MD, GREGORY S STUDENT
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ROTH, MD, JERRY M BUCKS
ROTH, MD, JONATHAN V PHILADELPHIA
ROTH, MD, KATALIN E PHILADELPHIA
ROTH, MD, MARIA T STUDENT
ROTH, DO, MICHAEL A MERCER
ROTH, DO, RAYMOND D UNION
ROTH, MD, RUSSELL B ERIE
ROTH JR, MD, GEORGE R DAUPHIN
ROTHACKER JR, MD, GERALD W LANCASTER
ROTHENBERGER, MD, MARVIN K LEHIGH
ROTHERMEL, MD, FRANKLIN J MONTOUR
ROTHKOPF, MD, BRAD M PHILADELPHIA
ROTHKOPF, MD, HENRY PHILADELPHIA
ROTHMAN, MD, DAVID L ALLEGHENY
ROTHMAN, MD, DAVID L MERCER
ROTHMAN, MD, KEITH S BUCKS
ROTHMAN, MD, RICHARD H PHILADELPHIA
ROTHROCK, MD, GILMORE M YORK
ROTHSCHILD, MD, JEFFREY M ALLEGHENY
ROTHSCHILD, MD, JOHN A LUZERNE
ROTHSTEIN, MD, EDWARD P BUCKS
ROTHSTEIN, MD, KENNETH D PHILADELPHIA
ROTOR, MD, MARILYN L LANCASTER
ROTTENBERG, DO, LOUIS PHILADELPHIA
ROTTMAN, DO, JOEY S PHILADELPHIA
ROTTSCHAEFER, MD, BERNARD L WESTMORELAND
ROUMM, MD, ALAN D DAUPHIN
ROUSCHE, MD, LORI E BUCKS
ROUSE, MD, PAUL V PHILADELPHIA
ROUSE, MD, S BRYAN BRADFORD
ROUSH JR, MD, ROBERT K DELAWARE
ROUSSEL, MD, PAULA L DAUPHIN
ROUX, MD, LUCIE C ALLEGHENY
ROVINSKI, MD, HELEN T LEBANON
ROVINSKY, DAVID STUDENT
ROVITO, MD, PETER F LEHIGH
ROVNER, MD, ERIC S PHILADELPHIA
ROVNER, MD, HAROLD PHILADELPHIA
ROVNO, MD, HERBERT PHILADELPHIA
ROWAN, MD, NOEL M BERKS
ROWAN, MD, PAUL J LANCASTER
ROWAN, MD, PHILIP T PHILADELPHIA
ROWAN, MD, SANDRA K BERKS
ROWE, DO, DAVID E BUCKS
ROWE, MD, LEE D PHILADELPHIA
ROWE, MD, MARC I ALLEGHENY
ROWE JR, MD, KENNETH W CAMBRIA
ROWEHL, MD, JANE B DAUPHIN
ROWLAND, MD, HAROLD A MONTGOMERY
ROWLAND, MICHAEL T STUDENT
ROWLAND III, MD, PAUL L ALLEGHENY
ROWLEY, MD, RICHARD S CHESTER
ROWMAN, MD, LEO PHILADELPHIA
ROXBY, ANDREW B STUDENT
ROXBY, MD, BRUCE S PHILADELPHIA
ROY, MD, JOHN PHILADELPHIA
ROY, MD, ROBERT H PHILADELPHIA
ROY III, MD, EMILE P CENTRE
ROYAL, MD, DAVID R CUMBERLAND
ROYAL, MD, MIKE A ALLEGHENY
ROYER, MD, THOMAS C MONTOUR
ROZANSKI, MD, STANLEY J BERKS
ROZANSKI JR, MD, LAWRENCE T PHILADELPHIA
ROZIN, MD, LEON ALLEGHENY
ROZWADOWSKI, MD, JACK V ERIE
ROZWADOWSKI, JEANNE M STUDENT
RUBASH, MD, HARRY E ALLEGHENY
RUBBO, MD, ERNEST R DAUPHIN
RUBEN, MD, JEROLD R WASHINGTON
RUBEN, MD, MALCOLM E WASHINGTON
RUBENFELD, MD, ARNOLD D ALLEGHENY
RUBENSTEIN, MD, MORTON J DAUPHIN
RUBENSTEIN, MD, RONALD C ALLEGHENY
RUBENSTONE, MD, JEANNE C CHESTER
RUBIN, MD, ANDREW M PHILADELPHIA
RUBIN, DO, CARL S PHILADELPHIA
RUBIN, MD, DEBORAH A PHILADELPHIA
RUBIN, MD, EMANUEL PHILADELPHIA
RUBIN, MD, EMMA LACKAWANNA
RUBIN, MD, ERIC D PHILADELPHIA
RUBIN, MD, HARVEY M ALLEGHENY
RUBIN, MD, I EDWARD PHILADELPHIA
RUBIN, MD, JEFFRY F MONTGOMERY
RUBIN, MD, JONATHAN D PHILADELPHIA
RUBIN, MD, JOYCE R PHILADELPHIA
RUBIN, MD, LORE R ALLEGHENY
RUBIN, MD, MARK J ALLEGHENY
RUBIN, DO, MORTON DELAWARE
RUBIN, MD, MORTON L DAUPHIN
RUBIN, MD, NATHAN W MONTGOMERY
RUBIN, MD, PETER E MONTGOMERY
RUBIN, MD, RICHARD M PHILADELPHIA
RUBIN, MD, SHARON PHILADELPHIA
RUBIN, MD, WALTER PHILADELPHIA
RUBINO, MD, MARK A ALLEGHENY
RUBINSON, ERIK S STUDENT
RUBINSTEIN, MD, DEBRA N ALLEGHENY
RUBIO, MD, EMIR W DELAWARE
RUBRIGHT, MD, GEORGE L BERKS
RUBRIGHT JR, MD, HERBERT C SCHUYLKILL
RUBRIGHT SR, MD, HERBERT C SCHUYLKILL
RUBY, MD, EDWARD B DELAWARE
RUDDEN, MD, ANN BUCKS
RUDICEL, MD, SALLY PHILADELPHIA
RUDIN, MD, JENNIFER E ALLEGHENY
RUDLEY, MD, LLOYD D PHILADELPHIA
RUDMAN, MD, RICHARD ALLEGHENY
RUDNICK, MD, HERMAN D PHILADELPHIA
RUDNICK, MD, JON ALLEGHENY
RUDNITZKY, MD, JEROME DELAWARE
RUDOLER, MD, SHARI W MONTGOMERY
RUDOLPH, JEFFREY A STUDENT
RUDOLPH, MD, JOSEPH PHILADELPHIA
RUDOLPH, MD, JOSEPH P ALLEGHENY
RUDOLPH, MD, KENNETH H LACKAWANNA
RUDOLPH, MD, ROBERT I BERKS
RUDOLPH, ROCHELLE D STUDENT
RUDOLPH JR, MD, SAMUEL F MONTGOMERY
RUDUSKY, MD, BASIL M LUZERNE
RUDZINSKI, AMY J STUDENT
RUEBEL, MD, ARMIN A BUCKS
RUEGER, MD, RAIMUND G ALLEGHENY
RUEHL, MD, WILLIAM W WASHINGTON
RUETSCHI, MD, MAJA S UNION
RUFE, MD, REDDING H BUCKS
RUFF, MD, CURTIS C BUTLER
RUFF, SANDRA L STUDENT
RUFFER, MD, JAMES E PHILADELPHIA
RUFFINI, MD, JOHN A DELAWARE
RUFFINI, MD, JOHN J DELAWARE
RUFFLE, MD, JOAN M DAUPHIN
RUFFNER, MD, ROBERT J ALLEGHENY
RUGART, MD, KARL F PHILADELPHIA
RUGEL, MD, STANLEY J PHILADELPHIA
RUGGIERO, DO, DOMINIC LACKAWANNA
RUGGIERO, MD, NICHOLAS J LUZERNE
RUGGIERO, MD, ROBERT A CHESTER
RUGGIERO, VINCENT STUDENT
RUGGIERO JR, ROBERT A STUDENT
RUHT, MD, BARRY A LEHIGH
RUIZ, MD, CESAR A ALLEGHENY
RULIN, MD, MARVIN C ALLEGHENY
RUMBAUGH, MD, MARSHALL U LUZERNE
RUMBAUGH, MD, ROSS S SOMERSET
RUMBAUGH, MD, WILLIAM P BEAVER
RUMBAUGH JR, MD, JAMES O PERRY
RUMBLE, MD, THOMAS R ALLEGHENY
RUMSEY, MD, WILLIAM P DELAWARE
RUNCO, MD, ANGELO S ALLEGHENY
RUNDORFF, MD, ROBERT L CAMBRIA
RUNK, MD, LORENZO G PHILADELPHIA
RUNYAN, DO, JOHN L COLUMBIA
RUNYEON, MD, WILLIAM K BERKS
RUPP, MD, ROBERT A FAYETTE
RUPP, TIMOTHY J STUDENT
RUSCHAK, MD, PAUL J ALLEGHENY
RUSH, MD, CALVIN C GREENE
RUSH, MD, JOHN F FAYETTE
RUSIN, MD, LAWRENCE C ERIE
RUSLI, MD, MICHAEL CHESTER
RUSNAK, JAMES M STUDENT
RUSS, DO, SHERYL A MONTOUR
RUSSEK, MD, EDWARD DAUPHIN
RUSSELL, MD, KAMAL B DELAWARE
RUSSELL, MD, MARIE O DELAWARE
RUSSELL, MD, RICHARD L DAUPHIN
RUSSELL, MD, W RANDALL MONTGOMERY
RUSSELL JR, MD, BERTRAM R CHESTER
RUSSIN, MD, MARY S UNION
RUSSINOVICH, MD, NICHOLAS A E ALLEGHENY
RUSSMAN, MD, RICHARD B ALLEGHENY
RUSSO, MD, ANTHONY F LANCASTER
RUSSO, MD, JOHN F SCHUYLKILL
RUSSO, MD, JOSEPH F ALLEGHENY
RUSSO, MD, LOUIS PHILADELPHIA
RUSSO, MD, MICHAEL P YORK
RUSSO, MD, PIERANTONIO PHILADELPHIA
RUSSO, MD, STEPHANIE F HUNTINGDON
RUSSO JR, DO, ANTHONY P ERIE
RUTBERG, MD, FRANKLIN L PHILADELPHIA
RUTBERG, MD, MICHAEL PHILADELPHIA
RUTENBERG, MD, HAROLD L PHILADELPHIA
RUTH, MD, COREY K PHILADELPHIA
RUTH, MD, D HENRY BEAVER
RUTH, MD, THOMAS K LANCASTER
RUTH II, DONALD H STUDENT
RUTHARDT JR, MD, FREDERICK W FAYETTE
RUTKOSKI, MD, PAMELA H LYCOMING
RUTLAND, MD, HEDLEY E YORK
RUTMAN, MD, DEANNA L ALLEGHENY
RUTT, MD, JOHN M LANCASTER
RUTT JR, MD, CLARENCE H LANCASTER
RUTTA, MD, DAVID LACKAWANNA

RUTTENBERG, MD, BERTRAM A	PHILADELPHIA
RUTTENBERG, DO, NORMAN F	PHILADELPHIA
RUZBARSKY, MD, JOSEPH J	LACKAWANNA
RUZICZKA, MD, LINDA A	ALLEGHENY
RYAN, MD, CHARLES S	PHILADELPHIA
RYAN, MD, DEBRA A	BRADFORD
RYAN, MD, JAMES G	ALLEGHENY
RYAN, MD, JOHN J	NORTHAMPTON
RYAN, MD, JOHN L	PHILADELPHIA
RYAN, MD, KATHLEEN F	PHILADELPHIA
RYAN, MD, LAWRENCE W	MONTGOMERY
RYAN, MD, MARILYN	DELAWARE
RYAN, MD, WILLIAM C	SOMERSET
RYAN, MD, WILLIAM F	MONROE
RYAN JR, DO, EDWARD F	DELAWARE
RYBARCZYK, MD, RICHARD M	LANCASTER
RYCHAK, MD, JOHN S	DAUPHIN
RYCKMAN, MD, WILLIAM F	WESTMORELAND
RYCZAK, MD, MARY	LACKAWANNA
RYDQUIST, JILL E	STUDENT
RYDZE, MD, RICHARD A	ALLEGHENY
RYDZE, MD, ROBERT A	ALLEGHENY
RYLKO, MD, PATRICIA A	DAUPHIN
RYMER, MD, DAVID B	ALLEGHENY
RYNIER, MD, DONALD L	LANCASTER
RYOO, MD, IN O	ALLEGHENY
RYSCAVAGE, MD, THOMAS S	YORK

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SAAB, MD, ELIE M	PHILADELPHIA
SAADE, ROSALMA	STUDENT
SAAVEDRA, MD, DIOGENES A	CRAWFORD
SABA, MD, PHILIP R	ALLEGHENY
SABANGAN, MD, JOEL S	BLAIR
SABATELLE, MD, ROBERT C	ALLEGHENY
SABATINO, MD, KENNETH C	PHILADELPHIA
SABEH, MD, GEORGE	ALLEGHENY
SABEH, MD, RAIF K	ALLEGHENY
SABLOSKY, MD, LESTER	MONTGOMERY
SABO, MD, ERIN M	ALLEGHENY
SABO, MD, ROBERT A	PHILADELPHIA
SABO, MD, ROBERT P	WESTMORELAND
SABOKBAR, MD, NASSER	MONTGOMERY
SABOL, MD, JOHN B	CUMBERLAND
SABOL, MD, JOSEPH G	ALLEGHENY
SABOL, MD, LOUISE J	MONTOUR
SABRE, MD, CRAIG A	MONROE
SABRI, MD, PHILIP J	FRANKLIN
SABUGO, MD, EVELYN F	PHILADELPHIA
SACCO, MD, MATTHEW A	ALLEGHENY
SACCO, MD, RUSSELL J	ALLEGHENY
SACHAKUL, MD, CHITRINEE	WESTMORELAND
SACHAROK, MD, CYNTHIA A	DELAWARE
SACHDEV, MD, RANJAN	NORTHAMPTON
SACHDEVA, MD, AJIT K	PHILADELPHIA
SACHDEVA, MD, RAVINDRA K	MERCER
SACHS, MD, MARVIN L	PHILADELPHIA
SACHS, MD, MURRAY	ALLEGHENY
SACK, MD, JEFFREY B	ALLEGHENY
SACKHEIM, MD, ROBERT	BUCKS
SACKL, MD, TERRI L	YORK
SACKMAN, MD, IRA	DAUPHIN
SACKS, MD, DAVID	BERKS
SACKS, MD, EDMOND J	CHESTER
SACKS, MD, ELLIS H	MONTGOMERY
SACKS, MD, HARRY J	PHILADELPHIA
SACKS, MD, RICHARD P	LEBANON
SACKS, DO, STEPHEN E	MONTGOMERY
SADEKNI, MD, MARWAN E	WESTMORELAND
SADIK, MD, SHAHIN A	PHILADELPHIA
SADKA, MD, GEORGE M	CLINTON
SADLER, MD, JOHN M	ALLEGHENY
SADOFF, MD, ROBERT L	MONTGOMERY
SADORRA, MD, NENITA CACDAC	PHILADELPHIA
SADOWSKI, MD, HUBERT F	ALLEGHENY
SADR, MD, FARROKH S	LEHIGH
SADWIN, MD, ARNOLD	PHILADELPHIA
SAEED, MD, AZMAT	SUSQUEHANNA
SAENZ, JENNIFER D	STUDENT
SAFIER, MD, JOEL	ALLEGHENY
SAFYAN, MD, ERIC L	ALLEGHENY
SAFYAN, MD, SUSAN L	ALLEGHENY
SAGALOW, MD, BARRY R	PHILADELPHIA
SAGAN, MD, ELIZABETH R	ALLEGHENY
SAGAWA, YUSUKE	STUDENT
SAGEL, DO, HENRY K	YORK
SAGEMAN, MD, MARC S	PHILADELPHIA
SAGEN, MD, WILLIAM	BUCKS
SAGER, MD, ETHEL	PHILADELPHIA
SAGER, DO, MARSHALL H	MONTGOMERY
SAGGE, MD, PERLA S	NORTHAMPTON
SAGHAFI, MD, DARIUS	WESTMORELAND
SAHA, MD, MADHUMITA	LEHIGH
SAHL, MD, HENRY G	PHILADELPHIA
SAHLANEY, MD, WILLIAM J	CAMBRIA
SAHOO, MD, DILLISWAR	SCHUYLKILL
SAHOO, MD, KASHINATH	BERKS
SAHOVEY, MD, JAMES R	ALLEGHENY
SAIDMAN, MD, BRUCE H	LUZERNE
SAIDMAN, MD, LESTER M	LUZERNE
SAIF, MD, NAHEED F	LEBANON
SAIFEE, MD, KUTUB M	ALLEGHENY
SAILER, JAY G	STUDENT
SAIONTZ, MD, HOWARD I	CAMBRIA
SAKACH, MD, VALERIE A	WASHINGTON
SAKKAL, MD, SAAD	MERCER
SAKOL, MD, PETER J	DAUPHIN
SALAK, MD, WASYL W	PHILADELPHIA
SALAM, MD, HASEEDA A	DELAWARE
SALAM, MD, MAHI	CHESTER
SALAND, MD, DAVID K	DELAWARE
SALAS, MD, MARTY M	CAMBRIA
SALATKA, MD, KARL W	WESTMORELAND
SALAZAR, MD, EDGARDO P	CARBON
SALAZAR, MD, LOUIS F	YORK
SALAZAR, MD, PEDRO A	LUZERNE
SALCEDO, MD, WILFREDO G	NORTHAMPTON
SALDANA, MD, IDEL J	JEFFERSON
SALEEM, MD, MOHAMMAD A	LACKAWANNA
SALEH, MD, AHMAB N	PHILADELPHIA
SALES, MD, IRVING J	PHILADELPHIA
SALES, MD, LAUREN E	PHILADELPHIA
SALES, MD, PHOENIX M	PHILADELPHIA
SALGADO, MD, EDWARD M	NORTHAMPTON
SALILENG, MD, FILEMON F	BERKS
SALINDONG, MD, JAIME P	MONTGOMERY
SALINGER, MD, DAVID J	FRANKLIN
SALKIND, MD, GARY D	DELAWARE
SALKIND, MD, GENE Z	PHILADELPHIA
SALKO, MD, GREGORY J	LACKAWANNA
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SALLAVANTI JR, MD, ROBERT A	STUDENT
SALMAN, MD, KARL	LACKAWANNA
SALNER, MD, NATHAN P	PHILADELPHIA
SALOMON, MD, MICHAEL A	WESTMORELAND
SALOWE, MD, DAVID R	BUCKS
SALTZBURG, DO, MICHAEL C	BLAIR
SALTZMAN, MD, MARCUS B	PHILADELPHIA
SALUP, MD, RAOUL R	ALLEGHENY
SALUTA, ARVIN B	STUDENT
SALVAGE, MD, ROBERT H	PHILADELPHIA
SALVATORE, MD, MICHAEL R	ERIE
SALVITTI, MD, E RONALD	WASHINGTON
SALVO, MD, PAUL J	PHILADELPHIA
SALVOZA, MD, MANUEL I	ALLEGHENY
SALZMAN, DO, GARY R	PHILADELPHIA
SAMAD, MD, MOHAMMAD A	NORTHMBRLAND
SAMADANI, MD, SIROOS R	ALLEGHENY
SAMAHA JR, MD, A MICHAEL	MONTGOMERY
SAMANTA, JOHAN E	STUDENT
SAMARASINGHE, MD, GUNASIRI	ERIE
SAMELSON, MD, LEO	YORK
SAMET, MD, SHERWOOD L	MONROE
SAMHOURI, MD, FAROUQ A	PHILADELPHIA
SAMIES, MD, JOHN H	LEHIGH
SAMII, MD, ABDOL H	LUZERNE
SAMII, MD, ALI M	CAMBRIA
SAMII, SORAYA M	STUDENT
SAMIMI, MD, FAROKH	PHILADELPHIA
SAMINATHAN, MD, THAMARAI	BUCKS
SAMITT, DO, JOEL L	LANCASTER
SAMITZ, MD, M HARRISS	PHILADELPHIA
SAMKOFF, MD, JUDITH S	DAUPHIN
SAMLIN, MD, BARRY	PHILADELPHIA
SAMM, PAUL L	STUDENT
SAMMARTINO, DO, ROBERT A	PHILADELPHIA
SAMODIO, MD, EVELYN I	BUCKS
SAMPATH, MD, KRISHNA	PHILADELPHIA
SAMPATHACHAR, MD, KADADABAM R	PHILADELPHIA
SAMUELS, MD, ALLEN J	ALLEGHENY
SAMUELS, MD, PHILIP	PHILADELPHIA
SAMUELS, MD, TODD L	DAUPHIN
SAMUELSEN, MD, THOMAS S	LACKAWANNA
SAMUELSON, MD, JOEL S	MONROE
SAND, DO, NEIL L	MONTGOMERY
SAND, MD, VIJAICHAND S	ELK/CAMERON
SANDBERG, MD, JAMES A	LEHIGH
SANDBERG, MD, THEODORE E	ALLEGHENY
SANDEL, MD, MARY E	PHILADELPHIA
SANDERS, ELMER T	STUDENT
SANDERS, MELINDA E	STUDENT
SANDERS, MD, PAUL	PHILADELPHIA
SANDERS, MD, RICHARD D	ALLEGHENY
SANDERS, MD, ROBERT E	WESTMORELAND
SANDERSON, MD, DOUGLAS K	DAUPHIN
SANDERSON, MD, VINCENT A	MERCER
SANDHAUS, MD, JULIUS L	LANCASTER
SANDHU, MD, BAKHSHISH S	BUCKS
SANDHU, MD, JASVINDER S	ALLEGHENY
SANDHU, MD, RAJINDER S	ALLEGHENY
SANDLER, MD, GLENN L	PHILADELPHIA
SANDLER, MD, KENNETH R	CHESTER
SANDLER, MD, SUSAN M	MONTGOMERY
SANDLES, EVERETT L	STUDENT
SANDO, MD, RALPH S	PHILADELPHIA
SANDOVAL, MD, CONCHITA Q	WESTMORELAND
SANDOVAL, JESSY C	STUDENT
SANDS, MD, EARL E	MONTGOMERY
SANDS, MD, JEFFREY J	LUZERNE
SANDS, DO, SETH C	MONTGOMERY
SANDSON, MD, GERALD B	ALLEGHENY
SANDSTROM, MD, PAUL H	ERIE
SANDSTROM JR, MD, FRANK T	MONTGOMERY
SANFORD, MD, FREDERIC E	LYCOMING
SANFORD, MD, ROBERT G	DAUPHIN
SANFORD, MD, ROBERT S	TIOGA
SANGHI, MD, JODH K	WARREN
SANGILLO, MD, CATHLEEN K	DAUPHIN
SANGILLO, MD, MARIO M	DAUPHIN
SANGODEYI, MD, OLU R	ALLEGHENY
SANGRUJEE, MD, KANNIKA L	ALLEGHENY
SANGRUJEE, MD, WEERASAK	ALLEGHENY
SANKAR, MD, NAGANATHAN S	BEAVER
SANKARAN, MD, MANICKAM	BLAIR
SANKARI, MD, MUHAMMED A	MCKEAN
SANNER JR, MD, EDGAR G	ALLEGHENY
SANPEDRO, MD, FLORO D	PHILADELPHIA
SANSONE, MD, THOMAS C	MONTGOMERY
SANSTEAD, MD, JOHN K	YORK
SANT RAM, MD, DEEPAK	CHESTER
SANTAMARIA, MD, FRANK R	WESTMORELAND
SANTANGELO, MD, MARSHA F	PHILADELPHIA
SANTANGELO, MD, SAMUEL C	MONTGOMERY
SANTARELLI, DO, ROCCO J	MONTGOMERY
SANTARSIERO, MD, D ANTHONY	LACKAWANNA
SANTEN, MD, RICHARD J	DAUPHIN
SANTIAGO, MD, DIOSPADO A	CAMBRIA
SANTIAGO, MD, EVELYN	ALLEGHENY
SANTIAGO, MD, JOSE W	MERCER
SANTIESTEBAN, MD, JOSEPH A	ALLEGHENY
SANTILLAN, MD, VICTOR H	BLAIR
SANTILLI, MD, THOMAS F	PHILADELPHIA
SANTINI, MD, LEWIS C	MONTOUR
SANTMAN, MARK	STUDENT
SANTO, MD, JEAN L	DAUPHIN
SANTOMENNA, MD, MICHAEL A	ERIE
SANTOPOLO, MD, ANTHONY C	DELAWARE
SANTORA, MD, ROBERT A	CRAWFORD
SANTORA, MD, THOMAS A	PHILADELPHIA
SANTORA JR, MD, DONALD C	ALLEGHENY
SANTORA JR, MD, FRANK J	ALLEGHENY
SANTORE, MD, FELICE J	DELAWARE
SANTORE, MD, LOUIS X	MONTGOMERY
SANTORO, MD, JEROME	PHILADELPHIA
SANTORO, MD, WILLIAM	BERKS
SANTOS, MD, ARTHUR M	ALLEGHENY
SANTOS, MD, CESAR R	LAWRENCE
SANTOS, MD, RODOLFO J	BUCKS
SANTOS, MD, RODOLFO R	SOMERSET
SANTOSO, MD, LIMJADI	ERIE
SANTUCCI, MD, FRANCESCO	ALLEGHENY
SANZ, DIANA L	STUDENT
SAOUAF, MD, ANTHONY G	PHILADELPHIA
SAPONARO, MD, STEPHEN A	STUDENT
SAPORITO, MD, JOSEPH J	ALLEGHENY
SAQUIN, MD, RAINELDO C	MCKEAN
SARACCO, MD, THOMAS R	ALLEGHENY
SARACHEK, MD, NORMAN S	LEHIGH
SARACINO, MD, DINO P	BEDFORD
SARADAR, MD, RAJA	ALLEGHENY
SARADAR, MD, RIAD	FAYETTE
SARAGOVI, MD, ARMAND A	PHILADELPHIA
SARAJEDINI, MD, HOSSAIN	MCKEAN
SARAN, MD, MADHUKAR	SUSQUEHANNA
SARAS, MD, HARRY P	MONROE
SARAS, MD, PETER L	LUZERNE
SARAVITZ JR, MD, EUGENE M	NORTHAMPTON
SARDESAI, MD, PRABHAKER G	ERIE
SARGEANT, MD, DELWYN H	PHILADELPHIA
SARGENT, MD, STEPHEN E	BUTLER
SARGINGER, MD, LARRY J	ELK/CAMERON
SARIEGO, MD, JOAQUIN	PHILADELPHIA
SARIN, MD, LOV K	PHILADELPHIA
SARIS, MD, ANNE L	MONTGOMERY
SARIS, MD, DEMETRIUS S	MONTGOMERY
SARIS-MECHENBIER, MD, LYDIA E	ALLEGHENY
SARKER, MD, CHITTA R	MONTGOMERY
SARKESSIAN, DO, ALBERT M	PHILADELPHIA
SARNER, MD, JOEL B	ALLEGHENY
SARNOWSKI, MD, ROBERT J	LACKAWANNA
SARON, MD, IRVIN J	NORTHAMPTON
SARP, MD, EDWARD J	BLAIR
SARSHIK, MD, MILTON	PHILADELPHIA
SARSHIK, MD, STUART A	BUCKS
SARTSCHEV, MD, CAROLINE A	ALLEGHENY
SARUBIN, MD, DANIEL R	LEHIGH
SARUK, MD, MICHAEL L	CHESTER
SARVER, MD, RAY G	WESTMORELAND
SARVER, MD, ROBERT O	ALLEGHENY
SARWAR, MD, SYEDA F	MONTGOMERY
SASSANI, MD, JOSEPH W	DAUPHIN
SATALOFF, MD, DAHLIA M	PHILADELPHIA
SATALOFF, MD, JOSEPH	PHILADELPHIA
SATALOFF, MD, ROBERT T	PHILADELPHIA
SATER, MD, RICHARD A	PHILADELPHIA
SATINSKY, ANDREA R	STUDENT
SATINSKY, MD, JONATHAN D	DELAWARE
SATRIALE, MD, RICHARD F	CHESTER
SATRIALE, MD, ROBERT O	CHESTER
SATTERLY, CLYDE H	STUDENT
SATYAM, MD, BHAGYALAKSHMI D	LUZERNE
SATZ, MD, WAYNE A	STUDENT
SAUCO, MD, M CONCEPCION	PHILADELPHIA
SAUER, MD, DIETER	WESTMORELAND
SAUER, MD, GARY G	ALLEGHENY
SAUER, MD, THOMAS S	NORTHAMPTON
SAUERS, MD, PATRICIA L	YORK
SAUL, MD, ALBERT	PHILADELPHIA
SAUL, MD, LEON J	PHILADELPHIA
SAUL, MD, ROBERT F	MONTOUR
SAULL, MD, SONDRA C	PHILADELPHIA
SAUNDERS, MD, CATHY L	WESTMORELAND
SAUNDERS, MD, CHARLES D	NORTHAMPTON
SAUNDERS, MD, RICHARD M	MONTGOMERY
SAUNDERSON JR, MD, ROBERT W	LANCASTER
SAUSSER, MD, EUGENE W	CUMBERLAND
SAVACOOL, MD, JACOB W	PHILADELPHIA
SAVAGE, MD, DONALD J	LUZERNE
SAVAGE, MD, MICHAEL P	PHILADELPHIA
SAVAGE, MD, PETER J	LUZERNE
SAVARESE, MD, RONALD P	PHILADELPHIA
SAVASTIO, MD, JOSEPH A	DAUPHIN
SAVELLI, BRENT A	STUDENT
SAVINESE, DO, STANLEY J	DELAWARE
SAVOIA, LEE A	STUDENT
SAVOIE, MD, LISA M	PHILADELPHIA
SAVORY, MD, WILLIAM J	DAUPHIN
SAWARDECKER, MD, SANDIP U	WESTMORELAND
SAWARDEKAR, MD, ARUN S	MERCER
SAWICKI, MD, EDWARD H	INDIANA
SAWIN, MD, HENRY S	MONTGOMERY
SAWIN, MD, STEPHEN W	PHILADELPHIA
SAWYER, MD, MICHAEL A J	PHILADELPHIA
SAWYNA, MD, VITALY	LEHIGH
SAXENA, MD, VARUN	BUCKS
SAXON, MD, ANDREA M	DELAWARE
SAXON, MD, JOSEPH G	DAUPHIN
SAYE JR, MD, WILLIAM H	DAUPHIN
SAYEN, MD, JOHN J	PHILADELPHIA
SAYERS, MD, FRANCIS P	NORTHMBRLAND
SAYERS, MD, KENNETH H	INDIANA
SAYLOR, MD, RANDALL M	BUTLER
SAYLOR, MD, RICHARD F	MONTGOMERY
SAYSON, MD, JOSE N	LEBANON
SBAT, DO, KENNEDY J	MONTGOMERY
SCAGLINE, RHONDA L	STUDENT
SCALLY, AMY P	STUDENT
SCANDURA IV, JOSEPH M	STUDENT
SCANLON, MD, MARY H	PHILADELPHIA
SCARAMUCCI, MD, JOHN C	ALLEGHENY
SCARANO, MD, VICTOR R	PHILADELPHIA
SCARPA, MD, HARRY C	MONTGOMERY
SCARPINO, MD, LEO J	LEHIGH
SCARSELLATO, MD, JOHN N	ALLEGHENY
SCERBO, MD, JAMES A	JEFFERSON
SCHAAF, MD, JOHN T	ERIE
SCHAAF, MD, RICHARD D	DELAWARE
SCHACHTER, MD, JOSEPH	ALLEGHENY
SCHACHTERLE, MD, RALPH E	LANCASTER
SCHADDER, CYNTHIA A	STUDENT
SCHADE, MD, JOHN F	LUZERNE
SCHADT, MD, DANIEL C	NORTHAMPTON
SCHADT, MD, MARK E	NORTHAMPTON
SCHAEBLER, MD, M LEE	BERKS
SCHAEFER, MD, C RUSSELL	ALLEGHENY
SCHAEFER, MD, THOMAS J	CAMBRIA
SCHAEFER, MD, THOMAS L	ALLEGHENY
SCHAEFFER, MD, CHARLES S	CENTRE
SCHAEFFER, MD, WILLIAM A	LANCASTER
SCHAEFFER JR, MD, WILLIAM E	LEBANON
SCHAENEN, MD, WENDY	DAUPHIN
SCHAFER, MD, CHARLES H	PHILADELPHIA
SCHAFER JR, MD, FRANCIS J	ALLEGHENY
SCHAFFER, MD, DAVID B	PHILADELPHIA
SCHAFFER, MD, DAVID N	DAUPHIN
SCHAFFER, MD, DAVID W	PHILADELPHIA
SCHAFFER, MD, ELLIOTT L	DELAWARE
SCHAFFER, LILLY H	STUDENT
SCHAFFER, MD, MICHAEL A	PHILADELPHIA
SCHAFFER, MD, MICHAEL G	PHILADELPHIA
SCHAIDER, MD, ELISABETH A M	ALLEGHENY
SCHAINKER, MD, BRUCE A	PHILADELPHIA
SCHALCOSKY, THOMAS V	STUDENT
SCHALET, DO, BENNETT D	PHILADELPHIA
SCHALL, MD, ROY F	ALLEGHENY
SCHALLER, MD, JAMES A	MONTGOMERY
SCHALLER, MD, JAMES L	PHILADELPHIA
SCHALLER, VINCENT E	STUDENT
SCHAMP, MD, RICHARD O	JEFFERSON
SCHANER, MD, PAUL J	ALLEGHENY
SCHANK, MD, DENNIS J	MONTGOMERY
SCHANTZ, DO, BEVERLY B	LANCASTER
SCHANTZ, MD, JOHN C	LANCASTER
SCHAPIRO, MD, ROLF L	ALLEGHENY
SCHARF, MD, ANN I	DELAWARE
SCHARF, MD, MICHAEL L	MONTGOMERY
SCHARLE, MD, W TIMOTHY	NORTHAMPTON
SCHARTEL, DO, ALBERT P	BERKS
SCHATANOFF, MD, DAVID	BLAIR
SCHATANOFF, MD, JOSEPH	PHILADELPHIA
SCHATZ, MD, NORMAN J	PHILADELPHIA
SCHAUB, MD, DAVID H	ALLEGHENY
SCHECKER, MD, NEIL H	PHILADELPHIA
SCHECTER, MD, BENJAMIN C	MONROE
SCHEER, MD, R SCOTT	CHESTER
SCHEERS, MD, GEORGE F	LUZERNE
SCHEFF, MD, ALICE M	PHILADELPHIA
SCHEIB, MD, FREDERICK J	WASHINGTON
SCHEID, MD, EDWARD R	ALLEGHENY
SCHEIN, MD, ALAN L	DAUPHIN
SCHEIN, MD, PHILIP S	MONTGOMERY
SCHEIN, MD, ROBERT A	ALLEGHENY
SCHEIN II, MD, GEORGE	ALLEGHENY
SCHEINER, ADAM J	STUDENT
SCHEINER, MD, ROBIN B	DELAWARE
SCHEINMAN, MD, HAROLD Z	ALLEGHENY
SCHELER-MANGIAPIA, MD, SANDRA L	FAYETTE
SCHELKUN, MD, P MICHAEL	BUCKS
SCHELL, MD, STEPHEN E	ERIE
SCHELL, MD, WALTER W	PHILADELPHIA
SCHELLENBERG, JOSEPH S	STUDENT
SCHELLHASE, KENNETH G	STUDENT
SCHENCK, DO, ARTHUR C	ERIE
SCHENCK, MD, PAUL H	LEHIGH
SCHENDEL, MD, PAUL S	YORK
SCHENFELD, MD, LOUIS A	CAMBRIA
SCHENKEL, MD, ERIC J	NORTHAMPTON
SCHER, MD, DAVID L	DAUPHIN
SCHERER, MD, BERNARD C	WESTMORELAND
SCHERR, MD, STUART A	PHILADELPHIA
SCHEUER, MD, JOHN W	LACKAWANNA
SCHEUERMANN, MD, HENRY A	DELAWARE
SCHEUERMANN, MD, RICHARD E	PHILADELPHIA
SCHIETROMA, MD, JOHN J	DAUPHIN
SCHIFF, MD, MELVIN M	ALLEGHENY
SCHIFFMAN, MD, MARA S	MONTGOMERY
SCHIFFMAN, MD, RAYMOND J	PHILADELPHIA
SCHILLER, MD, HERBERT M	PHILADELPHIA
SCHILLER, MD, RUTH P	BUCKS

SCHILLI, MD, RUDOLPH	CAMBRIA
SCHILLING, MD, JACQUELINE	DELAWARE
SCHILLING, MD, JOHN F	DELAWARE
SCHIMMER, MD, BARRY M	PHILADELPHIA
SCHINDLER, MD, ALAN M	PHILADELPHIA
SCHINDLER, JOHN T	STUDENT
SCHINDLER, MD, PETER D	CHESTER
SCHINFELD, MD, JAY S	MONTGOMERY
SCHINFELD, MD, LOUIS H	MONTGOMERY
SCHIOWITZ, MD, ALBERT	LUZERNE
SCHIOWITZ, MD, MARK F	LUZERNE
SCHIRK, MD, STEVEN K	YORK
SCHIRO, MD, JOHN C	DAUPHIN
SCHLACKMAN, MD, NEIL	BUCKS
SCHLAEPFER, CHARLES C	STUDENT
SCHLAFF, MD, LILLIAN T	PHILADELPHIA
SCHLAGER, MD, BARBARA A	BUCKS
SCHLAGER, MD, CHARLES E	YORK
SCHLANSKY, MD, RONALD M	CUMBERLAND
SCHLEGEL JR, MD, ROBERT J	YORK
SCHLEICHER, MD, STEPHEN M	LUZERNE
SCHLEIFER, MD, CHARLES R	PHILADELPHIA
SCHLESINGER, MD, ROBERT B	PHILADELPHIA
SCHLESINGER, MD, SAM	LUZERNE
SCHLESS, MD, ARTHUR P	CHESTER
SCHLESSEL, MD, RICHARD B	PHILADELPHIA
SCHLEZINGER, MD, NATHAN S	PHILADELPHIA
SCHLICHTING, MD, CHRISTINE M	PHILADELPHIA
SCHLITZER, MD, WILLIAM H	SCHUYLKILL
SCHLOSSBERG, MD, DAVID	PHILADELPHIA
SCHLOSSER, MD, DAVID E	LANCASTER
SCHMALTZ, MD, HARRY W	MONTOUR
SCHMELTZ, MD, RALPH	ALLEGHENY
SCHMEYER, MD, JON E	YORK
SCHMIDHOFER, MD, MARK	ALLEGHENY
SCHMIDT, MD, ARNOLD P	LUZERNE
SCHMIDT, DEBRA M	STUDENT
SCHMIDT, MD, H WILLIAM	MONTGOMERY
SCHMIDT, MD, STEPHEN L	BLAIR
SCHMIELER, MD, GEORGE C	WASHINGTON
SCHMITT, MD, CHARLES L	ALLEGHENY
SCHMITT, MD, HERMAN L	ALLEGHENY
SCHMITZ, MD, THOMAS J	ADAMS
SCHMUKLER, DO, ANITA G	PHILADELPHIA
SCHMUTZLER III, MD, ROBERT C	MONTGOMERY
SCHNALL, MD, BARRY	PHILADELPHIA
SCHNALL, MD, CHARLES	PHILADELPHIA
SCHNALL, MD, DAVID J	PHILADELPHIA
SCHNALL, MD, NATHAN	PHILADELPHIA
SCHNAUFER, MD, LOUISE	PHILADELPHIA
SCHNEE, MD, SCOTT S	VENANGO
SCHNEEBERG, MD, ARTHUR L	PHILADELPHIA
SCHNEEBERG, MD, J MYRON	PHILADELPHIA
SCHNEEBERG, MD, NORMAN G	PHILADELPHIA
SCHNEIDER, MD, BERNARD	PHILADELPHIA
SCHNEIDER, MD, JAN	PHILADELPHIA
SCHNEIDER, MD, JILL	PHILADELPHIA
SCHNEIDER, MD, JOHN A	ALLEGHENY
SCHNEIDER, MD, LAWRENCE H	PHILADELPHIA
SCHNEIDER, MD, MICHAEL P	ALLEGHENY
SCHNEIDER, MD, RICHARD R	ALLEGHENY
SCHNEIDER, MD, ROBERT E	ALLEGHENY
SCHNEIDER, MD, ROBERTA L	MONTGOMERY
SCHNEIDER, MD, SUSAN M	PHILADELPHIA
SCHNEIDERMAN, MD, MARC J	ALLEGHENY
SCHNEIMAN, MD, MAURICE H	PHILADELPHIA
SCHNELL, MD, BRIAN M	NORTHAMPTON
SCHNUR, PAUL J	STUDENT
SCHNURER, MD, CHARLES I	ALLEGHENY
SCHNURER, MD, MARK A	BEAVER
SCHOCK, MD, WILLIAM W	HUNTINGDON
SCHOCKER, MD, JACK D	BLAIR
SCHOENFELDER, MD, STEVEN J	UNION
SCHOENLEBER, MD, DANA B	MONTOUR
SCHOEPPNER, MD, ERIC	NORTHAMPTON
SCHOEPPNER, MD, GABRIELLE	NORTHAMPTON
SCHOFFSTALL, MD, JOHN M	PHILADELPHIA
SCHOFIELD, MD, JOYCE A	MONTGOMERY
SCHOFIELD, MD, R ALAN	MONTGOMERY
SCHOGEL, MD, KAREN L	PHILADELPHIA
SCHOLL, MD, HARVEY W	MONTGOMERY
SCHOLL JR, MD, HARVEY W	BUCKS
SCHOLLAERT, MD, RICHARD A	ALLEGHENY
SCHONAUER, MD, THOMAS D	YORK
SCHONDER III, JOHN F	STUDENT
SCHONFELD, MD, MARGERY B	BUCKS
SCHONROCK, MD, KRISTA L	LEHIGH
SCHOONOVER, CHRISTINE A	STUDENT
SCHOONOVER, MD, DANIEL K	MONTOUR
SCHOPFER, MD, RALPH E	LYCOMING
SCHORN, MD, VICTOR G	FRANKLIN
SCHORR, MD, NEAL A	ALLEGHENY
SCHOTT, MD, C RICHARD	DELAWARE
SCHOWALTER, MD, DONALD R	WESTMORELAND
SCHRADER, MICHAEL C	STUDENT
SCHRADER, MD, PATRICIA A	NORTHAMPTON
SCHRAGGER, MD, ALAN H	LEHIGH
SCHRAMM, MD, FRANK E	NORTHAMPTON
SCHRAN, MD, ALBERT G	DELAWARE
SCHRECK, MD, FRED M	NORTHMBRLAND
SCHRECKENGAUST, MD, ROBERT H	LACKAWANNA
SCHREIBER, MD, RICHARD	DAUPHIN
SCHREIBER, MD, RICHARD D	LEBANON
SCHREINER, MD, GLENWOOD R	LUZERNE
SCHREINER, MD, MARK S	PHILADELPHIA
SCHRENZEL, MD, STEVEN	DELAWARE
SCHROCK, MD, LAURA J	CAMBRIA
SCHROECKENSTEIN, MD, RICHARD F	CRAWFORD
SCHROEDER, MD, RICHARD D	CAMBRIA
SCHROGIE JR, MD, JOHN J	CHESTER
SCHRYVER, MD, THOMAS E	YORK
SCHUBERT, MD, BETH R	PHILADELPHIA
SCHUBERT, MD, JOHN J	LANCASTER
SCHUCKER, MD, CHARLES L	HUNTINGDON
SCHUCKER, MD, FORREST A	DAUPHIN
SCHUCKER, MD, JODI L	NORTHAMPTON
SCHUERCH, MD, CONRAD	MONTOUR
SCHUERER, DOUGLAS J E	STUDENT
SCHUESSLER, MD, PAUL W	NORTHAMPTON
SCHULHOFF, MD, JOHN W	ALLEGHENY
SCHULLER, MD, DIANE E	MONTOUR
SCHULMAN, MD, EDWARD S	PHILADELPHIA
SCHULMAN, MD, ELLIOTT A	PHILADELPHIA
SCHULMAN, MD, NORMAN	LUZERNE
SCHULTHEIS JR, MD, CARL F	MONTGOMERY
SCHULTZ, MD, CHRISTOPHER F	PHILADELPHIA
SCHULTZ, MD, EDWARD D	BLAIR
SCHULTZ, MD, EDWARD M	ALLEGHENY
SCHULTZ, MD, JULIUS	PHILADELPHIA
SCHULTZ, STEPHANIE L	STUDENT
SCHULTZ, MD, THEODORE A	WESTMORELAND
SCHULTZE, ROBERT L	STUDENT
SCHULZ, MD, JACOB A	LANCASTER
SCHULZ, VIRGINIA L	STUDENT
SCHUMACHER, MD, L RICHARD	MONTGOMERY
SCHUMACHER, LINDA A	STUDENT
SCHUMAN, MD, ROBERT A	LACKAWANNA
SCHUSTER, MD, ALBERT H	PHILADELPHIA
SCHUSTER, MD, ALLAN H	ALLEGHENY
SCHUSTER, MD, ROBERT T	CHESTER
SCHUTTE, MD, SHARON L	PHILADELPHIA
SCHWAB, MD, MORTON E	PHILADELPHIA
SCHWAB, MD, RICHARD J	PHILADELPHIA
SCHWAB, MD, ROBERT H	PHILADELPHIA
SCHWABE, MD, KARL G	DELAWARE
SCHWALB, MD, ALLEN J	PHILADELPHIA
SCHWALB, MD, NEIL S	PHILADELPHIA
SCHWAMM, MD, HARRY A	MONTGOMERY
SCHWARCZ, MD, HARRIET B	MONTGOMERY
SCHWARTZ, MD, ALAN J	PHILADELPHIA
SCHWARTZ, MD, ALEC R	ALLEGHENY
SCHWARTZ, MD, BARRY J	PHILADELPHIA
SCHWARTZ, MD, DANIEL N	ALLEGHENY
SCHWARTZ, MD, DONALD S	CHESTER
SCHWARTZ, MD, EMANUEL E	PHILADELPHIA
SCHWARTZ, MD, GARY M	DAUPHIN
SCHWARTZ, DO, GERSON	DELAWARE
SCHWARTZ, MD, GORDON F	PHILADELPHIA
SCHWARTZ, MD, HAROLD	PHILADELPHIA
SCHWARTZ, MD, HARRY W	PHILADELPHIA
SCHWARTZ, MD, IRA	SCHUYLKILL
SCHWARTZ, MD, JAN A	MONTOUR
SCHWARTZ, MD, JEFFREY H	PHILADELPHIA
SCHWARTZ, MD, JOEL D	ALLEGHENY
SCHWARTZ, MD, JOEL L	MONTGOMERY
SCHWARTZ, MD, JONATHAN	WESTMORELAND
SCHWARTZ, MD, LEONARD	ALLEGHENY
SCHWARTZ, MD, LINDEN M	PHILADELPHIA
SCHWARTZ, MD, LOUIS	PHILADELPHIA
SCHWARTZ, MD, MARC L	PHILADELPHIA
SCHWARTZ, MD, MELVIN H	LEHIGH
SCHWARTZ, MD, MICHAEL D	LEHIGH
SCHWARTZ, MD, MILTON A	BUCKS
SCHWARTZ, MD, NATALIO	MONTGOMERY
SCHWARTZ, MD, PETER A	BERKS
SCHWARTZ, MD, PETER L	BUCKS
SCHWARTZ, MD, RAYMOND	PHILADELPHIA
SCHWARTZ, MD, REUBEN B	PHILADELPHIA
SCHWARTZ, MD, ROBERT C	DAUPHIN
SCHWARTZ, MD, ROBERT M	ERIE
SCHWARTZ, MD, ROBERT P	PHILADELPHIA
SCHWARTZ, MD, RONALD J	MONTGOMERY
SCHWARTZ, MD, SHELDON M	LYCOMING
SCHWARTZ, MD, STACI J	PHILADELPHIA
SCHWARTZ, MD, STEPHEN L	PHILADELPHIA
SCHWARTZ, MD, SUSAN F	WESTMORELAND
SCHWARTZMAN, ERIC L	STUDENT
SCHWARTZMAN, GREGORY J	STUDENT
SCHWARZ, MD, GABRIEL A	PHILADELPHIA
SCHWARZ, MD, RICHARD A	BUCKS
SCHWEIKLE, MD, MARY R	LYCOMING
SCHWEIZER, MD, ROBERT A	DELAWARE
SCHWEIZER, MD, ROBERT R	BERKS
SCHWEMMER, DO, HELENE M	PHILADELPHIA
SCHWENDEMAN, MD, LESLIE J	ALLEGHENY
SCHWENTKER, ANN R	STUDENT
SCHWENTKER, MD, EDWARDE P	DAUPHIN
SCHWERHA, MD, JOSEPH J	ALLEGHENY
SCHWERIN, MD, WILLIAM F	ALLEGHENY
SCHWIEP, MD, FRANCIS	LEHIGH
SCHWINGE, MD, ELAINE A	LEHIGH
SCHWITER, MD, E JOSEPH	LUZERNE
SCIALLA, MD, SALVATORE J	LACKAWANNA
SCIAMANNA, CHRISTOPHER N	STUDENT
SCIARA, MD, CHRISTINE	DELAWARE
SCIASCIA, DO, KAREN M	NORTHAMPTON
SCIBAL, MD, GARY J	LANCASTER
SCIBETTA, MD, MARIO P	ERIE
SCIBILIA, MD, JAMES P	BEAVER
SCICCHITANO, MD, DAVID C	NORTHMBRLAND
SCICCHITANO, MD, LEON P	SCHUYLKILL
SCICUTELLA, DO, CAROL J	ALLEGHENY
SCINICO, MD, MARK W	LUZERNE
SCIOSCIA, MD, EUGENE A	ALLEGHENY
SCIOSCIA JR, MD, EUGENEA	ALLEGHENY
SCIUBBA, MD, ROCCO P	DELAWARE
SCIULLI, MD, ROBERT L	ALLEGHENY
SCLABASSI, MD, ROBERT J	ALLEGHENY
SCOBLIONKO, MD, DAVID P	NORTHAMPTON
SCOGLIETTI, MD, VINCENT C	ALLEGHENY
SCOGNO, CHARLES A	STUDENT
SCOLA, MD, ANTHONY J	PHILADELPHIA
SCOLA, FILOMENA M	STUDENT
SCOPELLITI, DEBRA	STUDENT
SCOPELLITI, MD, JOSEPH A	BRADFORD
SCORNAVACCHI, MD, JOSEPH M	BERKS
SCORNAVACCHI JR, MD, JOSEPH M	BERKS
SCORZA, LARI M	STUDENT
SCOTT, MD, ALVIN J	LUZERNE
SCOTT, MD, DONNA P	DELAWARE
SCOTT, MD, DOROTHY C	ALLEGHENY
SCOTT, MD, DURELLE T	LUZERNE
SCOTT, MD, EARL S	PHILADELPHIA
SCOTT, MD, HENRY	PHILADELPHIA
SCOTT, MD, HOWARD K	BUTLER
SCOTT, MD, J CLIFFORD	CHESTER
SCOTT, MD, JACK A	ALLEGHENY
SCOTT, MD, JOHN H	ALLEGHENY
SCOTT, DO, MARK E	DELAWARE
SCOTT, MD, NORMAN E	ALLEGHENY
SCOTT, MD, PHYLLIS B	TIOGA
SCOTT, DO, ROBERT C	LANCASTER
SCOTT, MD, THOMAS B	BRADFORD
SCOTT, MD, THOMAS F	ALLEGHENY
SCOTT, MD, THOMAS R	YORK
SCOTT JR, MD, S DAVID	MONTGOMERY
SCOTTI, MD, DANIEL M	PHILADELPHIA
SCOVAZZO, MD, MARY L	ALLEGHENY
SCOVERN, MD, HENRY	BERKS
SCRIBNER, MD, BRENDA C	PHILADELPHIA
SCULLIN III, MD, JOHN P	MERCER
SCULLY, MD, JOHN P	BERKS
SCUTELLA, MD, MICHEAL A	ERIE
SEARCY, MD, WILLIAM A	ALLEGHENY
SEARFOSS, MD, ROGER C	WESTMORELAND
SEARS, MD, ALAN J	DELAWARE
SEBASTIAN, MD, CARMELLA M	LACKAWANNA
SEBASTIAN, MD, EUGENE F	DAUPHIN
SEBASTIANELLI, MD, MARIO J	LACKAWANNA
SEBASTIANELLI, MD, WAYNE J	LACKAWANNA
SECHLER, MD, EDITH W	VENANGO
SECKINGER, MD, RAYMOND P	LEHIGH
SECOSKY, MD, JOSEPH J	ALLEGHENY
SEDA, MD, HECTOR J	BERKS
SEDACCA, MD, PAUL J	PHILADELPHIA
SEDLOVSKY, MD, MICHAEL Z	NORTHMBRLAND
SEEBER, MD, JOHN J	CAMBRIA
SEECOF, MD, RICHARD M	ALLEGHENY
SEEL, MD, MICHAEL J	STUDENT
SEELAUB, MD, JERE F	MONTGOMERY
SEEWALD, MD, TRACY R	ALLEGHENY
SEGAL, MD, ALLAN	BEAVER
SEGAL, MD, BERNARD L	PHILADELPHIA
SEGAL, MD, HERBERT E	CUMBERLAND
SEGAL, JODI B	STUDENT
SEGAL, MD, RICARDO	ALLEGHENY
SEGAL, MD, SCOTT	PHILADELPHIA
SEGARRA, MD, SERGIO	MERCER
SEGEDY, MATTHEW S	STUDENT
SEGRAVE-DALY, MD, STEPHEN L	MONROE
SEIAVITCH, MD, SAMUEL A	ALLEGHENY
SEID, DERICE P	STUDENT
SEIDEL, MD, AUDREY M	PHILADELPHIA
SEIDEL, MD, FREDERICK J	DAUPHIN
SEIDEL, MD, HORACE Y	NORTHAMPTON
SEIDERS, MD, ELIZABETH P	ALLEGHENY
SEIDL, MD, DANIEL C	YORK
SEIDLICH, MD, FRANKLIN T	DAUPHIN
SEIDNER, MD, MICHAEL R	MONTGOMERY
SEIFERT, MD, CAROL L	ALLEGHENY
SEIFERT, MD, GEORGE L	PHILADELPHIA
SEIFERT, DO, MARY C	ALLEGHENY
SEIFERT, DO, RAYMOND D	ALLEGHENY
SEIFERT, MD, RICHARD A	DELAWARE
SEIFERT, MD, THOMAS E	CAMBRIA
SEIFERTH, MD, WILLIAM J	ERIE
SEIGLE, MD, WALTER E	LACKAWANNA
SEINIGE, MD, URSULA L	PHILADELPHIA
SEIPLE, MD, HARVEY H	LANCASTER
SEITCHIK, MD, MURRAY W	PHILADELPHIA
SEITCHIK, MD, SCOTT H	PHILADELPHIA
SEITMAN, MD, DAVID T	BUCKS
SEITZ, MD, EDWARD R	ALLEGHENY
SEITZ, MD, NEVIN H	YORK
SEITZ JR, MD, HORACE M	PHILADELPHIA
SEKARAN, MD, KAMALESH K	BUTLER
SEKARAN, MD, BOMASUNDARAM K	BUTLER
SEKERES, MIKKAEL A	STUDENT
SEKHAR, MD, LALIGAM N	ALLEGHENY
SEKULA-PERLMAN, MD, ADRIENNE	PHILADELPHIA
SELBY, MD, CHARLES L	MONTGOMERY
SELICKMAN, MD, MITCHELL A	PHILADELPHIA
SELIG, MD, MICHAEL B	NORTHAMPTON
SELIG, MD, ROBERT M	PHILADELPHIA
SELIGER, MD, GUSTAV	DELAWARE
SELINGO, MD, JAMIE A	PHILADELPHIA
SELKER, MD, ROBERT G	ALLEGHENY
SELKOVITB, MD, SIDNEY	ALLEGHENY
SELL, MD, HARRY W	ALLEGHENY
SELLARO, DO, SALVATORE R	ERIE
SELLERS, MD, ALFRED M	PHILADELPHIA
SELTZER, MD, HARRY	ALLEGHENY
SELTZER, MD, JOSEPH L	PHILADELPHIA
SELTZER, MD, MAURICE	PHILADELPHIA
SELVARAJ, MD, MYLAPPAN	BUTLER
SELVARAJ, MD, VIJAYALAKSHMI	BUTLER
SELVARAYAN, MD, PHILIP T	LUZERNE
SEMANOFF, MD, THEOPHILA C	BUCKS
SEMBROT, MD, WILLIAM B	PHILADELPHIA
SEMINS, MD, HOWARD	ALLEGHENY
SEMPLE, MD, JOSEPH M	ERIE
SENAN, MD, PUSHPENDRA	ALLEGHENY
SENDZIK, MD, NESTOR I	BUCKS
SENECAL, MD, KEITH E	FRANKLIN
SENFT, MD, KAREN E	NORTHAMPTON
SENFT, MD, STEPHEN C	NORTHAMPTON
SENITA, MD, G ROBERT	ALLEGHENY
SENOUR, MD, CONNIE L	DAUPHIN
SENTER, MD, HOWARD J	ALLEGHENY
SENZON, SHARI L	STUDENT
SEO, MD, JIN S	BERKS
SEPESKY, VICTORIA M	STUDENT
SEPROSKY JR, MD, JOSEPH C	LACKAWANNA
SERAFY, MD, MICHAEL M	ALLEGHENY
SERBER, MD, WILLIAM	PHILADELPHIA
SERENE, MD, HARRY E	ALLEGHENY
SERFAS, MD, LEE S	NORTHAMPTON
SERGI, MD, MICHAEL A	BERKS
SERINE, MD, ENRICO A	LACKAWANNA
SERKES, MD, CONSTANTINE A	CHESTER
SERPICO, DO, PETER C	BUCKS
SERRANO, MD, ALBERTO C	PHILADELPHIA
SERVOSS, MD, SPENCER J	LYCOMING
SERWINT, MD, MICHAEL S	LYCOMING
SESKI, MD, JAN C	ALLEGHENY
SESSLER, MD, MONIQUE N	BERKS
SESSOMS, MD, FRANK E	ALLEGHENY
SETH, MD, PRABHAT	ALLEGHENY
SETH, MD, RAJENDRA N	PHILADELPHIA
SETHI, MD, SURENDRA K	BUTLER
SETLOCK, DO, WALTER W	SCHUYLKILL
SETTLE, MD, DANIEL F	PHILADELPHIA
SETTY, MD, POLEPALLI S	WESTMORELAND
SEVICK, MD, MYRON E	CENTRE
SEWAK, MD, MICHAEL E	CAMBRIA
SEWARDS, MD, PATRICK M	LEHIGH
SEWATSKY, MD, MARY F	LACKAWANNA
SEXTON JR, MD, GEORGE L	BERKS
SEYLER, MD, RAYMOND Q	DELAWARE
SGAMBATI, MD, MARIA	DAUPHIN
SGARLAT, MD, JOSEPH R	LUZERNE
SGRO, MD, ANTONIO	PHILADELPHIA
SHABLOSKI, REGAN P	STUDENT
SHACHNER, MD, MARK S	PHILADELPHIA
SHACKELFORD, MD, DONALD P	DAUPHIN
SHACKELFORD JR, MD, HOWARD L	ALLEGHENY
SHACKLEFORD, MD, ROBERT W	MONTGOMERY
SHACKLETT, MD, DOROTHY E	PHILADELPHIA
SHAD, MD, AZIZA T	DAUPHIN
SHADDUCK, MD, RICHARD K	ALLEGHENY
SHADDUCK, MD, SNEED P	BERKS
SHADE JR, DANIEL A	STUDENT
SHADLE, MD, CHESTER A	YORK
SHAEFFER, MD, JOSEPH M	BUCKS
SHAFER, MD, EDWARD A	LUZERNE
SHAFFER, MD, CAROLYN W	DAUPHIN
SHAFFER, MD, EUGENE M	BERKS
SHAFFER, MD, GEORGE W	BUCKS
SHAFFER, MD, HOWARD L	LAWRENCE
SHAFFER, MD, IRVIN G	BERKS
SHAFFER, MD, LAWRENCE A	MERCER
SHAFFER, DO, LINDA E	CAMBRIA
SHAFFER, MD, LIONEL B	MONTGOMERY
SHAFFER, MD, TERRY D	LAWRENCE
SHAFFER, MD, WALTER L	ALLEGHENY
SHAFIA, MD, HASS	PHILADELPHIA
SHAFIQUE, MD, MOHAMMAD	LYCOMING
SHAH, MD, AJIT N	ALLEGHENY
SHAH, MD, ANILKUMAR T	LUZERNE
SHAH, ASHISH S	STUDENT
SHAH, MD, CHAITANYA B	PHILADELPHIA
SHAH, MD, HARNISH V	BERKS
SHAH, MD, JITENDRA N	PHILADELPHIA
SHAH, MD, MAHENDRA K	SUSQUEHANNA
SHAH, MD, MANJULA S	JEFFERSON
SHAH, MD, MUBARIK A	BUCKS
SHAH, MD, MUKTA K	MIFFLIN/JUNI
SHAH, MD, NARAYAN	MONTOUR
SHAH, MD, NAYAN C	LACKAWANNA
SHAH, MD, RAHMAT	LACKAWANNA
SHAH, MD, RANJAN R	DELAWARE
SHAH, MD, RANJIT R	DELAWARE
SHAH, MD, RATAN S	WESTMORELAND
SHAH, MD, SATISH A	ADAMS
SHAH, MD, SHAILEN S	PHILADELPHIA
SHAH, MD, SHIRISH N	ALLEGHENY
SHAH, SUSIE S	STUDENT
SHAH, MD, SYED G	SCHUYLKILL
SHAH, MD, VINOD H	ALLEGHENY
SHAHEEN, MD, ROBERT G	BLAIR
SHAHID, MD, MIAN M A	CARBON
SHAIKH, MD, AYESHA R	LACKAWANNA
SHAIKH, MD, KHALEEL A	LACKAWANNA
SHAIKH, MD, M NASIR	WESTMORELAND
SHAKIN, MD, ELISABETH J	PHILADELPHIA
SHAKIN, MD, ERIC P	DELAWARE
SHAKTMAN, MD, BARRY D	PHILADELPHIA
SHALLEY, MD, ANN M	ALLEGHENY
SHAMAI, MD, HAROUN A	LEHIGH
SHAMBAUGH, MD, SHAWN C	LUZERNE
SHAMBLIN, MD, JERRY D	ALLEGHENY
SHAMES, MD, JEFFREY L	ALLEGHENY
SHAMMASH, MD, JONATHAN B	STUDENT
SHAMPAIN, MD, MARK P	LEHIGH

SHANAGHAN, DO, KEVIN J	LYCOMING
SHANAHAN, MD, J RUSH	PHILADELPHIA
SHANAHAN, MD, NANCY R	BUCKS
SHANE, MD, LOIS B	BRADFORD
SHANER, MD, CATHARINE L	LEHIGH
SHANFELD, MD, NORMAN M	DELAWARE
SHANK, MD, IRENE A	ALLEGHENY
SHANKAR, MD, V S	PHILADELPHIA
SHANMUGAM, MD, KASINATHAN	WARREN
SHANNON, MD, THOMAS O	MONTGOMERY
SHAPIRA, MD, EDITH L	ALLEGHENY
SHAPIRO, MD, ADAM M	ALLEGHENY
SHAPIRO, MD, ALVIN P	ALLEGHENY
SHAPIRO, MD, BERNARD	PHILADELPHIA
SHAPIRO, MD, BRYAN E	CAMBRIA
SHAPIRO, MD, CHARLES J	FRANKLIN
SHAPIRO, DO, ERIC B	DELAWARE
SHAPIRO, ERIC D	STUDENT
SHAPIRO, MD, HARVEY H	FRANKLIN
SHAPIRO, MD, JOHN A	BERKS
SHAPIRO, MD, LEONARD H	PHILADELPHIA
SHAPIRO, MD, LESTER F	ALLEGHENY
SHAPIRO, MD, MORRY	ALLEGHENY
SHAPIRO, MD, STEVEN L	YORK
SHAPIRO, MD, STUART H	PHILADELPHIA
SHAPIRO, MD, TIMOTHY A	BERKS
SHARBAUGH, MD, DONALD G	BEDFORD
SHARE, LISA J	STUDENT
SHARIFF, MD, HAJI M	PHILADELPHIA
SHARIFF, YASMEEN K	STUDENT
SHARIFI-AZAD, MD, SAID	PHILADELPHIA
SHARKEY, MD, THOMAS G	LUZERNE
SHARKEY JR, MD, SEAN J	PHILADELPHIA
SHARMA, MD, AMAR J	NORTHAMPTON
SHARMA, MD, BRAHMA N	ALLEGHENY
SHARMA, MD, JASHWANT K	ALLEGHENY
SHARMA, MD, KUSUM	WESTMORELAND
SHARMA, MD, MEERA V	LACKAWANNA
SHARMA, MD, OM P	NORTHAMPTON
SHARMA, MD, SUKH D	ERIE
SHARMAN, MD, MICHAEL H	WASHINGTON
SHARP JR, MD, JOHN W	LANCASTER
SHARPLESS, MD, EDWIN D	DELAWARE
SHARPNACK, MD, BRUCE C	WASHINGTON
SHARPS, MD, FRANK	PHILADELPHIA
SHARRA, MD, WILLIAM G	ALLEGHENY
SHARRAR, MD, ROBERT G	PHILADELPHIA
SHARRER, MD, MARGARET C	ALLEGHENY
SHASHIKUMAR, MD, V L	PHILADELPHIA
SHATTEN, MD, THOMAS A	ALLEGHENY
SHATZ, MD, RICHARD N	LYCOMING
SHAUB JR, MD, HOWARD G	BLAIR
SHAUGHNESSY, MD, MICHAEL J	ALLEGHENY
SHAVER, MD, JAMES A	ALLEGHENY
SHAVER, MD, JOHN C	ALLEGHENY
SHAVER, MD, VERNE C	ALLEGHENY
SHAW, DO, DONALD D	TIOGA
SHAW, MD, ELIZABETH V	DAUPHIN
SHAW, MD, ELLEN M	MONTGOMERY
SHAW, MD, GORDON A	LYCOMING
SHAW, MD, JAMES A	DAUPHIN
SHAW, PALMA M	STUDENT
SHAW, MD, RALPH A	PHILADELPHIA
SHAW III, MD, LEWIS C	DAUPHIN
SHAWALUK, MD, PAUL D	PHILADELPHIA
SHAY, MD, PAUL L	ALLEGHENY
SHEA, MD, FRANCIS J	PHILADELPHIA
SHEAFFER, MD, HAROLD C	DELAWARE
SHEARBURN III, MD, EDWIN W	BUCKS
SHEARER, MD, DAVID M	YORK
SHEARER, MD, DONALD E	LYCOMING
SHECHTER, MD, JAMINE L	PHILADELPHIA
SHECHTER, MD, JAY A	LACKAWANNA
SHECTER, DO, FREDRIC M	PHILADELPHIA
SHECTER, MD, JAMES S	YORK
SHEDD, MD, ANN C	ALLEGHENY
SHEDDEN, MD, ARTHUR H	MONTGOMERY
SHEDRO, MD, HECTOR	WESTMORELAND
SHEEDY, MD, JOHN G	BLAIR
SHEEHAN, MD, JOHN H	ALLEGHENY
SHEEHE, MD, DENNIS M	COLUMBIA
SHEELY, MD, RAYMOND F	ADAMS
SHEEP, MD, ROBERT E	FRANKLIN
SHEER, MD, GEORGE W	LACKAWANNA
SHEETS, MD, EVERETT O	PHILADELPHIA
SHEETS, MD, JAMES A	LEHIGH
SHEFFER, MD, M LEONARD	BERKS
SHEFFO, MD, GREGORY S	ALLEGHENY
SHEINBAUM, MD, ROY J	PHILADELPHIA
SHEKTMAN, MD, ARTHUR A	PHILADELPHIA
SHELANSKI, MD, SHARON L	PHILADELPHIA
SHELBY, MD, JOHN H	BERKS
SHELBY, MD, JOSEPH E	FAYETTE
SHELDON, DAVID G	STUDENT
SHELDON, MD, DOUGLAS L	LACKAWANNA
SHELLEY, MD, LISBETH E	ALLEGHENY
SHELLEY, MD, MARK H	MCKEAN
SHELLEY, MD, WILLIAM L	CUMBERLAND
SHELLING, MD, RICHARD E	BRADFORD
SHELLY, MD, ROBERT M	SUSQUEHANNA
SHELLY, MD, W DAYTON	WYOMING
SHELTON, MD, BARBARA	PHILADELPHIA
SHEMANSKI, MD, CLEM J	BERKS
SHENAI, MD, PUNDALIK G	DAUPHIN
SHENBERGER, MD, KEITH N	LYCOMING
SHENFIELD, MD, HENRY T	BRADFORD
SHENKIN, MD, HENRY A	PHILADELPHIA
SHEPARD, MD, WILLIAM R	MONTGOMERY
SHEPHERD, MD, LORI L	YORK
SHEPPARD, MD, EDITH S	MONTGOMERY
SHEPTAK, MD, PETER E	ALLEGHENY
SHER, MD, LIANE	PHILADELPHIA
SHER, MD, PAUL B	PHILADELPHIA
SHER, MD, SCOTT A	PHILADELPHIA
SHERBAN, MD, PAUL R	LANCASTER
SHERIF, MD, KATHERINE D	PHILADELPHIA
SHERLEKAR, MD, SANDEEP	PHILADELPHIA
SHERMAN, MD, ALFRED J	DAUPHIN
SHERMAN, MD, ANTHONY	PHILADELPHIA
SHERMAN, CAROLYN E	STUDENT
SHERMAN, MD, HENRY K	ALLEGHENY
SHERMAN, MD, M JACKSON	PHILADELPHIA
SHERMAN, MD, SAMUEL	ALLEGHENY
SHERMAN, MD, SUSAN J	PHILADELPHIA
SHERRY, MD, MICHAEL M	ALLEGHENY
SHERRY, MD, SOL	PHILADELPHIA
SHERTZER, MD, JOHN H	LANCASTER
SHERWIN, MD, EDWARD A	LACKAWANNA
SHERWIN, MD, NANCY M	DELAWARE
SHERWIN, MD, ROBERTA	PHILADELPHIA
SHERWIN, MD, WILLIAM K	MONTGOMERY
SHERWOOD, MD, ARTHUR W	WYOMING
SHERWOOD, MD, JOHN W	LUZERNE
SHESTAK, MD, KENNETH C	ALLEGHENY
SHETE, MD, LEENA P	WESTMORELAND
SHETTER, MD, THOMAS G	BUTLER
SHETTY, MD, ASHOK K	WESTMORELAND
SHETTY, MD, BALU B	ALLEGHENY
SHETTY, MD, K NARAYAN	BEAVER
SHETTY, MD, KARUNAKAR S	WESTMORELAND
SHETTY, MD, NANDALIKE S	MERCER
SHETTY, MD, RATNAKAR S	BEAVER
SHETZLEY, MD, CARL M	BUCKS
SHEVCHIK, MD, GRANT J	WESTMORELAND
SHIBEN, MD, TIM E	ALLEGHENY
SHICK, HUBERT	STUDENT
SHIEH, MD, KAN C	LEHIGH
SHIELDS, MD, JERRY A	PHILADELPHIA
SHIELDS, MD, JOHN J	MONTGOMERY
SHIELDS, MD, MARY S	LEHIGH
SHIELDS, MD, RALPH L	NORTHAMPTON
SHIELDS, MD, THOMAS J	MONTGOMERY
SHIELDS JR, MD, RICHARD A	PHILADELPHIA
SHIENBAUM, ALAN J	STUDENT
SHILLING, JACK W	STUDENT
SHIM, MD, CHUNGJA C	VENANGO
SHIM, MD, WAN S	DELAWARE
SHIN, MD, HEE JOON	NORTHAMPTON
SHIN, MD, HYUNKI	PHILADELPHIA
SHIN, KATHERINE	STUDENT
SHIN, MD, MAUNG T	ERIE
SHINDEL, MD, JAMES H	BLAIR
SHINDLER, MD, ROBERT L	DAUPHIN
SHINGALA, MD, ARUN J	LACKAWANNA
SHINN, MD, SARAH B	ALLEGHENY
SHINNICK, DO, JAMES P	PHILADELPHIA
SHIPKOVITZ, MD, HARVEY D	ALLEGHENY
SHIPSTONE, MD, ASHEESH	ALLEGHENY
SHIPTON, DO, WILLIAM E	SCHUYLKILL
SHIREY, MD, ELAINE D	CHESTER
SHISHAK, MD, ARYO A	WAYNE/PIKE
SHISLER, MD, FREDERICK H	MONTGOMERY
SHIU, TRUDI	STUDENT
SHIVDE, MD, PINAKINI	ERIE
SHMOKLER, MD, MITCHELL F	DELAWARE
SHOBER, DO, DAVID R	LUZERNE
SHOCKMAN, MD, JOEL	PHILADELPHIA
SHOEMAKER, MD, DAVID L	ALLEGHENY
SHOEMAKER, MD, DAVID M	BUCKS
SHOEMAKER, MD, LARRY D	PHILADELPHIA
SHOEMAKER, MD, MARGRIT M	LYCOMING
SHOEMAKER, MD, PATRICIA L	LEHIGH
SHOEMAKER, DO, STEPHEN N	LUZERNE
SHOENER, MD, JOHN A	ALLEGHENY
SHOENTHAL, MD, DONALD R	ALLEGHENY
SHOENTHAL, MD, WILLIAM J	BUCKS
SHOGAN, MD, JEFFREY E	ALLEGHENY
SHOGRY, MD, ROBERT N	ALLEGHENY
SHOLDER, MD, ARNOLD J	ALLEGHENY
SHOLEVAR, MD, FARHAD	LEHIGH
SHONBERG, MD, BARBARA H	BUCKS
SHONBERG, MD, IRVING L	ALLEGHENY
SHONNARD, MD, JOHN W	VENANGO
SHOOK III, MD, WILLIS D	ALLEGHENY
SHOPE, MD, EARL S	BEDFORD
SHORE, MD, PAUL D	DELAWARE
SHORE, MD, ROBERT A	MONTGOMERY
SHORE, MD, ROGER J	CLARION
SHORE, MD, SEYMOUR M	PHILADELPHIA
SHORE, MD, SIDNEY	MONTGOMERY
SHORE, MD, STEPHEN A	DELAWARE
SHORE, MD, STEPHEN R	LEHIGH
SHOURAIE, MD, ZARRIN	PHILADELPHIA
SHOVLIN, MD, J MICHAEL	LACKAWANNA
SHOWERS, MD, DONNA H	MONTGOMERY
SHRAGER, DANIEL I	STUDENT
SHRAGER, DO, LARRY M	DELAWARE
SHRAGER, MD, MORTON W	PHILADELPHIA
SHREINER, MD, DAVID P	ALLEGHENY
SHRIFT, MD, CRAIG A	DAUPHIN
SHROFF, MD, FAROOK K	LUZERNE
SHROM, MD, STANLEY H	DELAWARE
SHU, MD, JASON C	LYCOMING
SHUBERT, MD, DUANE D	DAUPHIN
SHUBIN, MD, HARRY	PHILADELPHIA
SHUE, MD, WILLIAM M	YORK
SHUGERT, MD, GUY S	BEAVER
SHUGERT, MD, JOHN H	BEAVER
SHUKLA, MD, ROHITKUMAR S	FRANKLIN
SHULKIN, MD, DAVID J	PHILADELPHIA
SHULKIN, MD, MARK W	DELAWARE
SHULL JR, MD, WILLIAM H	PHILADELPHIA
SHULMAN, MD, JOHN F	PHILADELPHIA
SHULTZ, MD, BARRY S	BERKS
SHULTZ, MD, ROBERT G	LANCASTER
SHULTZ, MD, THOMAS L	BUCKS
SHUMAN, MD, CHARLES R	PHILADELPHIA
SHUMAN, MD, JOHN F	BERKS
SHUMAN, MD, LEIGH S	LANCASTER
SHUMAN, MD, NANCY A	BERKS
SHUMAN, MD, SANDRA J	PHILADELPHIA
SHUNG-LU, MD, TA	BRADFORD
SHURMAN, BRETT D	STUDENT
SHUSHAN, MD, ROBERT S	DELAWARE
SHUSTER, MD, EUGENE	PHILADELPHIA
SHUSTERMAN, MD, RICHARD D	BUCKS
SHUTACK, DO, JOHN G	PHILADELPHIA
SHUTTER, MD, WALTER D	WESTMORELAND
SHUTTLEWORTH, MD, LAMONT V	ALLEGHENY
SHY, MD, ROSEMARY R	PHILADELPHIA
SHYAMALAN, MD, JAYALAKSHMI	PHILADELPHIA
SHYAMALAN, MD, NELLIATE C	PHILADELPHIA
SHYMANSKY, MD, J STEPHEN	ALLEGHENY
SHYMANSKY, MD, LAURA M	ALLEGHENY
SHYNN, MD, TAE I	LUZERNE
SIA, MD, JOSE K	BEAVER
SIAR, MD, W JOHN	JEFFERSON
SIBERSKI, DUANE D	STUDENT
SIBERSKI, MD, JOHN R	LUZERNE
SIBINGA, MD, MAARTEN S	DELAWARE
SIBLEY, MD, ROBERT E	LACKAWANNA
SIBOLBORO, MD, ISABELO Z	INDIANA
SICEB, LAURA	STUDENT
SICHER, MD, BRUNO P	MCKEAN
SICILIANO, LOUIS J	STUDENT
SICKEL, MD, EDWARD F	DAUPHIN
SICKORA, DO, MARK S	ALLEGHENY
SICONOLFI, MD, ERNEST P	ALLEGHENY
SICURANZA, MD, MICHAEL J	YORK
SIDARI, MD, JUDE F	LUZERNE
SIDAROUS, MD, MICHAEL G	LUZERNE
SIDDIQI, MD, SIRAJ U	ALLEGHENY
SIDDIQI, MD, TARIQ	PHILADELPHIA
SIDDOWAY, MD, LYLE A	YORK
SIDHU, PREETIKA K	STUDENT
SIDOR, MD, CAROLYN F	PHILADELPHIA
SIDOROV, MD, JAAN E	MONTOUR
SIEBE, MD, JACK C	FAYETTE
SIEBER, MD, PAUL R	LANCASTER
SIEBER, MD, WILLIAM K	ALLEGHENY
SIEGAL, JOEL D	STUDENT
SIEGEL, MD, AYN D	UNION
SIEGEL, MD, BERNARD	PHILADELPHIA
SIEGEL, MD, BONITA H	PHILADELPHIA
SIEGEL, MD, DAVID M	ALLEGHENY
SIEGEL, MD, JOSEPH F	WASHINGTON
SIEGEL, MD, MARY C	CHESTER
SIEGEL, MD, PAUL D	PHILADELPHIA
SIEGEL, MD, SEYMOUR	PHILADELPHIA
SIEGEL, MD, WILLIAM	BUCKS
SIEGELBAUM, MD, STEVEN P	DAUPHIN
SIEGER, MD, DAVID D	LANCASTER
SIEGFRIED, MD, JAY W	PHILADELPHIA
SIEGFRIED, MD, MYRTLE M	LEHIGH
SIEGLER, MD, PETER E	PHILADELPHIA
SIEGRIST, MD, J DONALD	LANCASTER
SIEMS, LAURA J	STUDENT
SIEPER, DO, WILLIAM J	WESTMORELAND
SIEPSER, MD, STEVEN B	CHESTER
SIESHOLTZ, MD, THOMAS S	BUCKS
SIEWERS, MD, CHRISTIANE	ALLEGHENY
SIEWERS, MD, RALPH D	ALLEGHENY
SIGAFOOS, EXEC SEC, SALLY	LANCASTER
SIGAL, MD, MICHAEL B	ALLEGHENY
SIGEL, MD, BERNARD	PHILADELPHIA
SIGLER, MD, MILES H	PHILADELPHIA
SIGMUND, MD, WILLIAM J	LANCASTER
SIGNORELLA, MD, LOUIS	WASHINGTON
SIGUENZA, MD, ROBERT F	DAUPHIN
SIH, MD, PHILIP G	MONTGOMERY
SIHA, MD, VICTOR L	ALLEGHENY
SIKER, MD, EPHRAIM S	ALLEGHENY
SIKORSKI, CYNTHIA S	STUDENT
SILBERMAN, MD, DAVID A	BUCKS
SILBERMAN, MD, HARVEY D	PHILADELPHIA
SILBERMAN, MD, IRA	PHILADELPHIA
SILBERMAN, MD, LESLIE J	ALLEGHENY
SILBERMAN, MD, ROBERT M	NORTHAMPTON
SILBERSTEIN, MD, MARSHA M	PHILADELPHIA
SILBERSTEIN, MD, STEPHEN D	PHILADELPHIA
SILBERT, MD, RICHARD R	LACKAWANNA
SILER, MD, JANET N	PHILADELPHIA
SILIQUINI, MD, JOHN J	PHILADELPHIA
SILK, MD, RAYMOND E	PHILADELPHIA
SILKO, MD, GARY J	WASHINGTON
SILLARS, MD, CHARLES H	MONTGOMERY
SILVA-LOPEZ, MD, EDIBALDO	MONTOUR
SILVAGGIO, MD, THERESA	ALLEGHENY
SILVER, MD, BARRY A	MONTGOMERY
SILVER, MD, BERNICE S	PHILADELPHIA
SILVER, MD, BRUCE G	DELAWARE
SILVER, MD, FRANK	PHILADELPHIA
SILVER, MD, ISRAEL O	DAUPHIN
SILVER, MD, LAURENCE M	MONTGOMERY
SILVER, MD, LAWRENCE S	DAUPHIN
SILVER, MD, LYNNE J	STUDENT
SILVER, DO, MARC R	PHILADELPHIA
SILVER, MD, RICHARD C	DELAWARE
SILVER, MD, SAUL J	ALLEGHENY
SILVER, MD, SCOTT J	YORK
SILVER, MD, STEPHEN C	DELAWARE
SILVERBERG, MD, ALAN	CHESTER
SILVERBERG, MD, ALAN L	PHILADELPHIA
SILVERBERG, MD, BRUCE J	LEHIGH
SILVERBERG, MD, DANIEL M	LEHIGH
SILVERBERG, MD, JAY H	ALLEGHENY
SILVERBERG, MD, ROBERT L	BERKS
SILVERBLATT, MD, BERNARD L	ALLEGHENY
SILVERBLATT, MD, MARVIN L	ALLEGHENY
SILVERIO, MD, JOHN	CHESTER
SILVERMAN, MD, ALAN R	ALLEGHENY
SILVERMAN, MD, ALEXANDER	ALLEGHENY
SILVERMAN, MD, EDWARD J	BERKS
SILVERMAN, MD, HOWARD A	LEHIGH
SILVERMAN, MD, JAMES F	LAWRENCE
SILVERMAN, MD, JERRY D	ALLEGHENY
SILVERMAN, MD, JOSEPH S	BLAIR
SILVERMAN, MD, MENDEL	ALLEGHENY
SILVERMAN, MD, MORTON I	LEHIGH
SILVERMAN, MD, MORTON L	MONTGOMERY
SILVERMAN, MD, MYRON H	YORK
SILVERMAN, MD, STANLEY P	MONTGOMERY
SILVERMAN, MD, STUART L	ALLEGHENY
SILVERMAN, MD, WILLIAM H	NORTHAMPTON
SILVERMAN, MD, WILLIAM S	PHILADELPHIA
SILVERS, MD, ABIGAIL A	MONTGOMERY
SILVERS, MD, ARTHUR H	DELAWARE
SILVERSTEIN, MD, ALAN J	ALLEGHENY
SILVERSTEIN, MD, CHARLES E	ALLEGHENY
SILVERSTEIN, MD, DANIEL K	LUZERNE
SILVERSTEIN, MD, DAVID H	JEFFERSON
SILVERSTEIN, MD, LEONARD I	MONTGOMERY
SILVERSTEIN, DO, SCOTT D	LANCASTER
SILVERSTEIN, SCOTT L	STUDENT
SILVERSTINE, MD, LESLIE B	MCKEAN
SILVERTON, MD, SUSAN F	MONTGOMERY
SILVESTRI, MD, ARCHIMEDE J	PHILADELPHIA
SILVIS, MD, HARRY J	WASHINGTON
SIM, MD, HYUN S	ARMSTRONG
SIMAN, MD, BERNARD	PHILADELPHIA
SIMBRA, MARIA E	STUDENT
SIMERMAN, MD, LEE PAUL	PHILADELPHIA
SIMKINS, MD, JO M	ALLEGHENY
SIMMONDS, MD, MARY A	DAUPHIN
SIMMONDS, MD, ROBERT T	ALLEGHENY
SIMMONS, MD, AGNES H	PHILADELPHIA
SIMMONS, MARK L	STUDENT
SIMMONS, MD, RICHARD L	ALLEGHENY
SIMMONS, MD, WILLIAM	ALLEGHENY
SIMMS, MD, GEORGE R	DAUPHIN
SIMON, DANIELE	STUDENT
SIMON, MD, KATHRYN K	MONTGOMERY
SIMON, MD, WILLIAM H	PHILADELPHIA
SIMONE, MD, FRANK J	INDIANA
SIMONE, MD, SAMUEL T	ALLEGHENY
SIMONIAN, MD, THOMAS M	ERIE
SIMONS, MD, CARL I	BUCKS
SIMONS, MD, RICHARD J	DAUPHIN
SIMONS, MD, ROBERT M	MONTGOMERY
SIMONS, MD, WILLIAM M	MONROE
SIMONSEN, MD, RONALD W	WARREN
SIMONSON, MD, ANDREW C	PHILADELPHIA
SIMPSON, MD, JOSEPH W	PHILADELPHIA
SIMPSON, MD, ROY W	LACKAWANNA
SIMPSON, ZACHARY W	STUDENT
SIMS, MD, CYNTHIA J	ALLEGHENY
SIMUNI, MD, TATYANA	PHILADELPHIA
SINAIKO, MD, PETER A	BUCKS
SINCAVAGE, MD, JOSEPH T	DELAWARE
SINCLAIR, MD, CATHERINE P	WASHINGTON
SINCLAIR, MD, MICHAEL C	LEHIGH
SINCLAIR, MD, STEPHEN H	PHILADELPHIA
SINE-KARASICK, DO, MADELYN	MONTGOMERY
SINGER, MD, BARRY L	MONTGOMERY
SINGER, MD, EDWARD S	PHILADELPHIA
SINGER, MD, FRED	PHILADELPHIA
SINGER, MD, IRVIN	PHILADELPHIA
SINGER, MD, JEROME	DELAWARE
SINGER, MD, JOSEPH D	MONTGOMERY
SINGER, MD, MARY V	DAUPHIN
SINGER, MD, RAYMOND L	LEHIGH
SINGER, MD, WILLIAM H	LEHIGH
SINGH, MD, AJAY P	SOMERSET
SINGH, MD, AMARJEET R	BEAVER
SINGH, MD, ARVIND K	LACKAWANNA
SINGH, MD, BIJAI B	INDIANA
SINGH, MD, DALJIT	ALLEGHENY
SINGH, MD, DALJIT	WESTMORELAND
SINGH, MD, DATAR	ALLEGHENY
SINGH, MD, GEETA	ALLEGHENY
SINGH, MD, GURCHARAN	PHILADELPHIA
SINGH, MD, GURDIAL N	NORTHMBRLAND
SINGH, MD, GURMIT	ALLEGHENY
SINGH, MD, GURSHARAN	SCHUYLKILL
SINGH, MD, MALKIT	FAYETTE
SINGH, MD, RAJENDRA	SCHUYLKILL
SINGH, MD, SURENDER	LANCASTER
SINGH, MD, USHA D	WESTMORELAND
SINGH, MD, VIJAI P	FAYETTE
SINGHI, MD, SUSHIL K	ALLEGHENY
SINGLETON, MARLYNN	STUDENT
SINGLEY, MD, THOMAS L	FAYETTE
SINHA, MD, LINA M	PHILADELPHIA
SINHA, MD, RAJ KAMAL	PHILADELPHIA
SINK, MD, JAMES D	PHILADELPHIA
SINKER, MD, DALE V	PHILADELPHIA
SINOR, MD, BAKHTI	ALLEGHENY
SINZ, MD, ELIZABETH H	ALLEGHENY
SIPES, MD, DUANE E	FRANKLIN
SIPES, MD, EARL K	LEHIGH
SIRIANNI, MD, ARCHIE J	PHILADELPHIA
SIRIO, MD, CARL A	DAUPHIN
SIRIPONG, MD, SILPACHAI	LAWRENCE
SIRKEN, DO, DAVID H	PHILADELPHIA

SIRKIN, MD, JONATHAN B	PHILADELPHIA
SIROTNAK, MD, JOHN J	LACKAWANNA
SIROTTA, MD, PAUL B	LEHIGH
SITKOFF, DO, ANDREW D	CHESTER
SIU, MD, CLARE C	WAYNE/PIKE
SIVALINGAM, MD, ARUNAN	PHILADELPHIA
SIVALINGAM, MD, JOCELYN F	PHILADELPHIA
SIVENDRAN, MD, THARMALINGAM	ADAMS
SIVITZ, MD, MARTA E	PHILADELPHIA
SIVITZ, MD, MICHAEL C	MONTGOMERY
SIVULICH, MD, MICHAEL J	CAMBRIA
SKALINA, MD, STEFAN M	DELAWARE
SKAROFF, MD, RICHARD M	PHILADELPHIA
SKEDROS, MD, DEMETRIOS G	ALLEGHENY
SKEEN, MD, JAMES T	DAUPHIN
SKEENS, MD, JOSEPH L	ALLEGHENY
SKEIST, MD, BARRY P	BRADFORD
SKERRETT, MD, PHILIP V	PHILADELPHIA
SKETTINO, MD, JOSEPH A	LACKAWANNA
SKIENDZIELEWSKI, MD, JOHN J	MONTOUR
SKINKER III, MD, BENJAMIN M	ALLEGHENY
SKINNER, MD, DOUGLAS V	ALLEGHENY
SKINNER III, MD, ROBERT W	LANCASTER
SKLAROFF, MD, DAVID M	PHILADELPHIA
SKLAROFF, MD, ROBERT B	PHILADELPHIA
SKOBIERANDA, KATHE R	STUDENT
SKOLNICK, MD, BRUCE A	PHILADELPHIA
SKOLNICK, MD, KENNETH B	BEAVER
SKONIECZKI III, MD, STAN R	LANCASTER
SKORINKO, MD, KENNETH P	NORTHAMPTON
SKORPINSKI, MD, EDWARD W	PHILADELPHIA
SKOTNICKI, DO, ROBERT A	DAUPHIN
SKOVIRA, MD, EDWARD M	LACKAWANNA
SKOVRON, MD, MICHAEL	ERIE
SKOWRONSKI, MD, THEODORE J	MONTGOMERY
SKRENTA, MD, RICHARD J	ALLEGHENY
SKRENTNY, MD, THOMAS T	BLAIR
SKROMAK, MD, STANLEY J	PHILADELPHIA
SKUBICK, MD, DANIEL L	MONTGOMERY
SKURA, MD, DOUGLAS S	ALLEGHENY
SKUTCHES, MD, JOSEPH M	NORTHAMPTON
SKVERSKY, MD, NORMAN J	PHILADELPHIA
SKWEIR, MD, LEON A	LEHIGH
SKWIRUT, MD, FRANK A	DELAWARE
SLABIC, MD, PETER P	ERIE
SLABIC, MD, STAN F	ERIE
SLABYJ, MD, NATALKA A	DAUPHIN
SLADE, MD, ROBERT N	NORTHAMPTON
SLADKIN, MD, KENNETH R	BUCKS
SLAGLE, MD, EDWARD H	ALLEGHENY
SLAP, MD, JOSEPH W	PHILADELPHIA
SLATER, MD, HARVEY	ALLEGHENY
SLATER, MD, KENNETH C	CARBON
SLATER, MD, ROBERT	DELAWARE
SLAVIN, MD, DOROTHY A	PHILADELPHIA
SLAVIN, MD, JAMES W	PHILADELPHIA
SLAVIN, DO, MICHAEL J	PHILADELPHIA
SLAVISH, MD, LYDIA G	BERKS
SLAVKIN, MD, MARVIN D	ALLEGHENY
SLAYTON, MD, ROBERT I	ALLEGHENY
SLEDZ, MD, ANN MARIE	NORTHAMPTON
SLEMENDA, MD, WILLIAM D	BEAVER
SLENKER, MD, KEVIN F	LANCASTER
SLEZAK, MD, JOSEPH A	WESTMORELAND
SLICK, MD, GREGORY	BEDFORD
SLIMMER JR, MD, SAMUEL C	SCHUYLKILL
SLIWINSKI, MD, STANLEY J	BUCKS
SLOAN, MD, CHARLES R	FAYETTE
SLOAN, MD, RICHARD W	YORK
SLOANE, MD, BRUCE B	PHILADELPHIA
SLOANE, MD, CHARLES E	WESTMORELAND
SLOANE, MD, PAUL	PHILADELPHIA
SLOCHOWER, MD, DENNIS	PHILADELPHIA
SLOMIANY, MD, WALTER P	WASHINGTON
SLOMPAK, MD, CAROL A	LEHIGH
SLOTHOUR, MD, EDWARD F	DAUPHIN
SLOVAK, MD, JOHN P	LANCASTER
SLOVAK, DO, MICHAEL J	LUZERNE
SLUHOCKI, DO, MARK	LUZERNE
SMAHA, MD, LYNN A	BRADFORD
SMALL, MD, RICHARD E	YORK
SMALL, MD, ROY S	LANCASTER
SMALLEY, MD, ARTHUR J	YORK
SMALLOW, MD, STEVAN A	MONTGOMERY
SMART, MD, LAWSON C	CRAWFORD
SMEAL, MD, WILLIAM E	CAMBRIA
SMELTZER, MD, KENNETH L	DAUPHIN
SMIGOCKI JR, MD, GENE C	LANCASTER
SMILEY, MD, JOSEPH W	DELAWARE
SMINK JR, MD, ROBERT D	DELAWARE
SMITH, MD, A MITCHELL	PHILADELPHIA
SMITH, MD, ARTHUR E	PHILADELPHIA
SMITH, MD, ARTHUR K	PHILADELPHIA
SMITH, MD, BARTON L	BERKS
SMITH, MD, BUSTER DEANGELO	PHILADELPHIA
SMITH, MD, CATHERINE S	LACKAWANNA
SMITH, MD, CHARLENE M	BUCKS
SMITH, DO, CHARLES E	ALLEGHENY
SMITH, MD, CHARLES F	LEHIGH
SMITH, DO, COLEEN M	LANCASTER
SMITH, MD, DAVID A	DAUPHIN
SMITH, MD, DAVID A	BUCKS
SMITH, MD, DAVID G	PHILADELPHIA
SMITH, MD, DAVID L	BUCKS
SMITH, MD, DAVID R	MONTGOMERY
SMITH, MD, DEAN A	LUZERNE
SMITH, MD, DENNIS R	UNION
SMITH, MD, DONALD C	LUZERNE
SMITH, MD, DONALD H	NORTHAMPTON
SMITH, MD, EARL B	ALLEGHENY
SMITH, MD, EDGAR C	DELAWARE
SMITH, MD, EDWARD G	MERCER
SMITH, MD, ELLEN L	PHILADELPHIA
SMITH, MD, EUGENE C	LANCASTER
SMITH, MD, GARY L	ALLEGHENY
SMITH, MD, GARY M	LUZERNE
SMITH, MD, GREGORY N	ALLEGHENY
SMITH, MD, GREGORY T	ALLEGHENY
SMITH, MD, IAN D	LANCASTER
SMITH, MD, IVAN S	MONTGOMERY
SMITH, MD, JACK D	WESTMORELAND
SMITH, MD, JAMES K	ALLEGHENY
SMITH, MD, JAMES M	CUMBERLAND
SMITH, MD, JAMES W	YORK
SMITH, MD, JAN D	ALLEGHENY
SMITH, MD, JERE P	LEHIGH
SMITH, MD, JOHN M	YORK
SMITH, MD, JOHN R	ALLEGHENY
SMITH, MD, JOHN W	ALLEGHENY
SMITH, MD, JOSEPH L	MONTOUR
SMITH, MD, KAIGHN	PHILADELPHIA
SMITH, MD, LINDA M	LEBANON
SMITH, MD, MARIA B	DELAWARE
SMITH, MD, MARY L	MONTGOMERY
SMITH, MD, MONICA E	PHILADELPHIA
SMITH, MD, PAUL H	DAUPHIN
SMITH, MD, RAYMOND L	BERKS
SMITH, RICK D	STUDENT
SMITH, MD, ROBERT C	ALLEGHENY
SMITH, MD, ROBERT G	WARREN
SMITH, MD, ROBERT W	MONTGOMERY
SMITH, MD, ROGER M	MONTGOMERY
SMITH, MD, RONALD E	BERKS
SMITH, MD, RUSSELL C	CHESTER
SMITH, MD, SANDRA J	DAUPHIN
SMITH, MD, STEPHEN H	BUCKS
SMITH, MD, THOMAS C	HUNTINGDON
SMITH, MD, THOMAS W	JEFFERSON
SMITH, MD, VICTORIA T	BLAIR
SMITH, MD, WADE R	ALLEGHENY
SMITH, MD, WALTER E	ALLEGHENY
SMITH, MD, WALTER K	WESTMORELAND
SMITH, MD, WARREN S	ALLEGHENY
SMITH, MD, WILLIAM D	DELAWARE
SMITH, MD, WILLIAM P	CAMBRIA
SMITH, MD, WILLIAM T	ALLEGHENY
SMITH IV, MD, CHRISTOPHER A	PHILADELPHIA
SMITH JR, MD, B DAVISON	DELAWARE
SMITH JR, MD, BENJAMIN V	ALLEGHENY
SMITH JR, MD, CHESTER L	MONROE
SMITH JR, MD, EDGAR C	PHILADELPHIA
SMITH JR, MD, GEORGE S	LEHIGH
SMITH JR, MD, H ALEX	LUZERNE
SMITH JR, MD, HAROLD A	MONTOUR
SMITH JR, MD, J STANLEY	DAUPHIN
SMITH JR, MD, JAMES W	BEAVER
SMITH JR, MD, MORGAN T	MONTGOMERY
SMITH JR, MD, PERRY C	WASHINGTON
SMITH JR, MD, ROSS H	ALLEGHENY
SMOKER, MD, CYNTHIA B	BERKS
SMOLEN, DO, DANIEL A	DELAWARE
SMOLINSKI, DO, WILLIAM J	LEHIGH
SMOLKO, MD, JAMES M	YORK
SMOLKO, MD, JAMES R	YORK
SMOLKO, MD, MILAN J	LACKAWANNA
SMOOKE, MD, MARK E	MIFFLIN/JUNI
SMOYER, MD, RONALD L	CAMBRIA
SMULLEN, MD, SEAN M	PHILADELPHIA
SMULLENS, MD, STANTON N	PHILADELPHIA
SMYSER, MD, LINDA M	MONTGOMERY
SMYTH, MD, LAWRENCE T	NORTHAMPTON
SMYTHE, MD, PEGGY A	ALLEGHENY
SMYTHE, MD, WILLIAM R	PHILADELPHIA
SNEDDEN, MD, HAL E	MONTGOMERY
SNEDDEN, MD, MICHAEL H	MONTGOMERY
SNEERINGER, DO, THOMAS D	CRAWFORD
SNEFF, MD, EUGENE M	BLAIR
SNELL JR, MD, EDWARD D	ALLEGHENY
SNIDER, MD, B LEONARD	ERIE
SNIDER, MD, CAMERON F	STUDENT
SNITZER, MD, ARNOLD J	ALLEGHENY
SNITZER, MD, LEWIS S	CAMBRIA
SNODGRASS JR, MD, W HOMER	ALLEGHENY
SNOOK, MD, MARY ELLEN	PHILADELPHIA
SNOVER, MD, SETH W	MONTOUR
SNOW, MD, LAURENCE H	PHILADELPHIA
SNOW, MD, ROSS A	ERIE
SNYDER, DO, ALLAN R	BUCKS
SNYDER, MD, ALLEN P	ALLEGHENY
SNYDER, MD, BARRY J	BUCKS
SNYDER, MD, BARRY J	CLARION
SNYDER, MD, DAVID C	BEAVER
SNYDER, MD, DIEHL M	LEBANON
SNYDER, MD, EARL J	LEBANON
SNYDER, MD, HARRY D	MONTGOMERY
SNYDER, MD, HENRY R	YORK
SNYDER, MD, JOHN M	NORTHAMPTON
SNYDER, MD, KENNETH R	PHILADELPHIA
SNYDER, MD, KERMAN	PHILADELPHIA
SNYDER, LORI S	STUDENT
SNYDER, MD, MARVIN C	CARBON
SNYDER, MD, RANDALL W	LACKAWANNA
SNYDER, DO, RICHARD K	LEHIGH
SNYDER, MD, RICHARD L	LANCASTER
SNYDER, MD, RICHARD W	MONTGOMERY
SNYDER, MD, ROBERT D	CHESTER
SNYDER, MD, ROBERT L	NORTHAMPTON
SNYDER, DO, SAMUEL K	PHILADELPHIA
SNYDER, SCOTT G	STUDENT
SNYDER, MD, STANLEY	LEHIGH
SNYDER, MD, STUART	PHILADELPHIA
SNYDER III, MD, HOWARD MCC	PHILADELPHIA
SNYDER JR, MD, CHARLES F	NORTHAMPTON
SNYDER JR, MD, CHARLES P	WESTMORELAND
SNYDERMAN, MD, CARL H	ALLEGHENY
SNYDERMAN, MD, DEBORAH A	PHILADELPHIA
SNYDERMAN, MD, RUBEN	ALLEGHENY
SNYDMAN, MD, LEONARD	PHILADELPHIA
SOBEL, MD, ADAM C	STUDENT
SOBEL, JOSEPH B	STUDENT
SOBEL, MD, RICHARD M	PHILADELPHIA
SOBER, MD, DIANE M	ALLEGHENY
SOBERS-BROWN, MD, KAREN D	PHILADELPHIA
SOBIESKI, MD, JOSEPH T	CAMBRIA
SOBLE, MD, MARC G	YORK
SOBOTA, BRET T	STUDENT
SOCOL, DAVID C	STUDENT
SOCRATES, MD, JESS U	YORK
SODEMAN, MD, WILLIAM A	PHILADELPHIA
SODOWICK, MD, BRADFORD C	PHILADELPHIA
SODUMS, MD, MARCIS T	BRADFORD
SOFFE, MD, ALVIN M	PHILADELPHIA
SOFFER, MD, MARVIN	PHILADELPHIA
SOFFIETTI, MD, JOHN H	BUTLER
SOFFRONOFF, MD, PIERCE	ALLEGHENY
SOIFER, DO, NEAL E	LACKAWANNA
SOISSON JR, MD, FERDINAND L	CAMBRIA
SOKALCHUK, MD, ANDREW	PHILADELPHIA
SOKIL, MD, ALEXIS BOHDAN	PHILADELPHIA
SOKOL, MD, JOEL H	DELAWARE
SOKOL, MICHAEL C	STUDENT
SOLAN, MD, JAMES A	WESTMORELAND
SOLAN, MD, MERRILL J	DELAWARE
SOLANKI, NISHA S	STUDENT
SOLANO JR, MD, FRANCIS X	ALLEGHENY
SOLBERG, MD, BYRNE L	DELAWARE
SOLI, MD, SOLEIMAN M	PHILADELPHIA
SOLIC, MD, JOHN J	CENTRE
SOLIMAN, MD, EZZAT M	WYOMING
SOLIMAN, MANAL M	STUDENT
SOLIS, MD, J ANDREW	BUCKS
SOLIT, DAVID B	STUDENT
SOLIT, RICHARD L	STUDENT
SOLIT, MD, ROBERT W	PHILADELPHIA
SOLL, MD, DAVID B	PHILADELPHIA
SOLLENBERGER, MD, LARRY L	DAUPHIN
SOLLENBERGER, MD, LAURA B	BLAIR
SOLLENBERGER, DO, STANTON E	FRANKLIN
SOLLER, MD, HERBERT I	DAUPHIN
SOLLOT, STEPHEN A	STUDENT
SOLOMON, MD, CYNTHIA A	LUZERNE
SOLOMON, DO, DENNIS R	PHILADELPHIA
SOLOMON, MD, ELIAS M	LANCASTER
SOLOMON, DO, ERIC D	BUCKS
SOLOMON, MD, HOWARD J	WESTMORELAND
SOLOMON, MD, MARK P	PHILADELPHIA
SOLOMON, MD, SAMUEL J	YORK
SOLOMON, MD, SOLOMON D	ADAMS
SOLOSHAR, LESLIE B	STUDENT
SOLOT, DO, JERALD A	ALLEGHENY
SOLOTOFF, MD, STEPHEN A	MONTGOMERY
SOLOW, MD, EDWARD A	PHILADELPHIA
SOLOW, MD, IRWIN A	ALLEGHENY
SOLOWAY, MD, STEPHEN	DELAWARE
SOLTER, MD, ALAN W	ALLEGHENY
SOMA, MD, JOSEPH J	LACKAWANNA
SOMABUNDARAM, MD, ANANUYA	NORTHAMPTON
SOMERS, MD, ERNEST E	FRANKLIN
SOMERS, MD, HERBERT J	PHILADELPHIA
SOMERS, MD, KEITH S	ALLEGHENY
SOMERS, MD, LAURENCE A	PHILADELPHIA
SOMERS, MD, ROBERT G	PHILADELPHIA
SOMERS, MD, WILLIAM R	LYCOMING
SOMERSET, DO, WILLIAM J	ALLEGHENY
SOMMA, MD, RICHARD M	LUZERNE
SOMMER, MD, DEBORAH L	ALLEGHENY
SOMMER, MD, JOHN T	DELAWARE
SOMMER, MD, VICKI M	BLAIR
SOMMERFELD, MD, JAMES P	LAWRENCE
SONBOLIAN, MD, NASSER	ALLEGHENY
SONDER, MD, HESTER M	PHILADELPHIA
SONDER, MD, MAX J	PHILADELPHIA
SONG, MD, MICHAELA C	PHILADELPHIA
SONG, MD, SANG W	BUCKS
SONG, MD, STEVEN S	MONTGOMERY
SONG, SUNG W	STUDENT
SONG, MD, YOUNG J	WESTMORELAND
SONG, MD, YUNG-DOO	PHILADELPHIA
SONGY JR, KENNETH A	STUDENT
SONNE, MD, JOHN C	PHILADELPHIA
SONNEBORN, MD, DUANE G	PHILADELPHIA
SONSINI, MD, GREGG A	MONTGOMERY
SOOJIAN, MD, MICHAEL M	DELAWARE
SOPCHAK, MD, MICHAEL A	YORK
SORARUF IV, MD, LOUIS P	CHESTER
SORBER, MD, JON A	WYOMING
SORBER, MD, WILLIAM A	LYCOMING
SORENSEN, MD, ALFRED L	WASHINGTON
SORIANO, MD, CLAVER S	ALLEGHENY
SORIANO JR, MD, MANUEL G	ELK/CAMERON
SORICELLI, MD, RHONDA L	PHILADELPHIA
SORICELLI, MD, RICHARD R	DELAWARE
SORKIN, MD, HARDY L	CHESTER
SOROKANICH, MD, STEPHEN	LACKAWANNA
SOROKANICH, MD, STEPHEN	LACKAWANNA
SOROSKY, MD, JOEL I	DAUPHIN
SORR, MD, EDWARD M	ALLEGHENY
SORTINO, MD, ANTONIO	ALLEGHENY
SOSIS, MD, ARTHUR C	LEHIGH
SOSS, DO, MURRAY C	PHILADELPHIA
SOTELO, MD, AUGUSTO	WESTMORELAND
SOTEREANOS, MD, DEAN G	ALLEGHENY
SOTO, MD, ANGELA M	DAUPHIN
SOTOODEHFAR, MD, RAHIM	ALLEGHENY
SOTOS, MD, L NICHOLAS	ARMSTRONG
SOTOS, MD, PETER N	ARMSTRONG
SOTOS, MD, STEVEN N	ALLEGHENY
SOTTILE, ELISA M	STUDENT
SOTUS, MD, PETER C	MERCER
SOUDER, MD, C LAWRENCE	LEHIGH
SOUDER, MD, FRANCIS R	BUCKS
SOUDER, MD, RONALD L	BUCKS
SOUDERS, MD, THOMAS B	BERKS
SOUILLIARD, MD, DONALD H	BUCKS
SOUNDARARAJAN, MD, RANGANATHA	LYCOMING
SOUNDARARAJAN, VIDYA	STUDENT
SOUSER, MD, ROSLYN C	MONTGOMERY
SOUTHERLAND, NATALIA J	STUDENT
SOVETSKY, DO, CHARLES L	DELAWARE
SPADARO, MD, DONNA P	VENANGO
SPADONI, MD, JOSEPH L	LEHIGH
SPAETH, MD, GEORGE L	PHILADELPHIA
SPAGNA, MD, PASCHAL M	PHILADELPHIA
SPAGNOLETTI, MD, LOUIS	PHILADELPHIA
SPAGNOLI, MD, MARIE V	ADAMS
SPAHR, MD, ROBERT C	MONTOUR
SPANARD, MD, RUSSELL A	ALLEGHENY
SPANGLER, MD, JOHN G	MONTOUR
SPANOGIANS, MD, ANGELO J	WASHINGTON
SPAZIANI, MD, JOSEPH T	LUZERNE
SPEACE, MD, GEORGE F	LUZERNE
SPEAKE, MD, MARK R	UNION
SPEARS, MD, LAURA S	YORK
SPEARS, MD, PAUL F	YORK
SPECTER, MD, JANET S	PHILADELPHIA
SPECTOR, MD, GUS	CHESTER
SPECTOR, DO, HOWARD L	LUZERNE
SPEEDY, MD, HARRY W	WESTMORELAND
SPEERS, MD, HERBERT K	BUCKS
SPEICHER, MD, JULIE M	LACKAWANNA
SPEICHINGER, MD, JAMES P	LYCOMING
SPELLER, MD, J FINTON	PHILADELPHIA
SPELLMAN, MD, WILLIAM H	MONTGOMERY
SPELTS, MELINDA K	STUDENT
SPENCE, DO, MICHAEL W	MONROE
SPENCER, MD, DEAN W	CRAWFORD
SPENCER, MD, DONALD LYNN	CHESTER
SPENCER, MD, H NEWTON	DELAWARE
SPENCER, MD, JAMES H	LAWRENCE
SPENCER, MD, JEANNE P	CAMBRIA
SPENCER, MD, JOHN A	PHILADELPHIA
SPERANZA, MD, DAVID N	LUZERNE
SPERLING, MD, DAVID M	ALLEGHENY
SPERLING, MD, HERBERT V	ALLEGHENY
SPERLING, MD, VERA R	ALLEGHENY
SPERRAZZA, JIM C	STUDENT
SPIEGEL, MD, JOSEPH R	PHILADELPHIA
SPIELMAN, MD, SCOTT R	PHILADELPHIA
SPIELVOGEL, MD, RICHARD L	PHILADELPHIA
SPIKER, MD, DUANE G	ALLEGHENY
SPILLMAN, MD, MURRAY K	LANCASTER
SPILSBURY, MD, PAUL R	MONTOUR
SPINA, MD, CARMEN M	BUTLER
SPINA, MD, NANCY R	BUTLER
SPINA JR, MD, JOSEPH	DELAWARE
SPINGOLA, MD, CHARLES E	BUTLER
SPINNER, MD, MORTON H	MONROE
SPINNEY, MD, CARMEN E	LYCOMING
SPINO, MD, PASCAL D	WESTMORELAND
SPINOLA, ANTHONY	STUDENT
SPINUZZA, MD, THOMAS J	FAYETTE
SPIRITOS, MD, MICHAEL D	MONTGOMERY
SPIRO, MD, PAUL D	BUCKS
SPITLER III, MD, WILLIAM M	LANCASTER
SPITZ, MD, EUGENE B	PHILADELPHIA
SPITZ, MD, LAWRENCE K	PHILADELPHIA
SPITZER, DO, IRA E	BUCKS
SPITZER, MD, STANLEY	PHILADELPHIA
SPIVACK, MD, JACK	BUCKS
SPIVEY, MD, WILLIAM H	MONTGOMERY
SPLAIN, DO, DENNIS J	LEHIGH
SPLANE, MD, BRUCE L	MONTOUR
SPOCK, MD, NICHOLAS	NORTHMBRLAND
SPOEHR, MD, LUTHER W	ALLEGHENY
SPOLL, DO, EDWARD A	NORTHAMPTON
SPORN, MD, DANIEL P	BRADFORD
SPOTTS, DOUGLAS A	STUDENT
SPOTTS, MD, RICKE L	LEBANON
SPRANDIO, MD, JOHN D	PHILADELPHIA
SPRATT, MD, CHARLES E	MONTGOMERY
SPRATT, MD, ROBERT H	MONTGOMERY
SPRING, MD, DEBORAH A	LUZERNE
SPRINGER, MD, DAVID T	DELAWARE
SPRINGER, MD, JAY M	MONTGOMERY
SPRINGER III, MD, ROBERT M	LANCASTER
SPURRIER, MD, DAVID J	CUMBERLAND
SQUADRITO JR, MD, JAMES F	MONTGOMERY
SQUIERS, MD, ELIZABETH C	MONTOUR
SRIDHARA, MD, C R	PHILADELPHIA
SRIDHARAN, MD, MALINI	PHILADELPHIA
SRIHARSHA, MD, PATALAM S	COLUMBIA
SRINIVASAGAM, MD, NARASIMMAN	ALLEGHENY
SRINIVASAN, MD, VENKATRAMAN	ALLEGHENY
SRIVASTAVA, MD, BRIJ B	DELAWARE
SRIVASTAVA, MD, POONAM	NORTHMBRLAND
SRIVASTAVA, MD, SHEONATH P	CAMBRIA
SRODES, MD, CHARLES H	ALLEGHENY
SROUJI, MD, MAURICE N	PHILADELPHIA

SROUJI, MD, SAMIR J	DAUPHIN
SROUR, MD, JAMES W	YORK
ST ANDRE, MD, MARY L	ALLEGHENY
ST JOHN, MD, KELLY M	PHILADELPHIA
STAAB, MD, JEFFREY P	ALLEGHENY
STAAS JR, MD, WILLIAM E	PHILADELPHIA
STABILE, MD, JEROME G	NORTHAMPTON
STABLER, MD, CRAIG L	LYCOMING
STACHECKI, SHARON A	STUDENT
STACHER, MD, ERIC D	GREENE
STACHNIAK, MD, LINDA M	DAUPHIN
STACK, MD, WILLIAM T	PHILADELPHIA
STACKS JR, MD, JACOB C	DAUPHIN
STAEBLER, MD, ROBIN J	BERKS
STAFFORD, MD, CALVIN R	DELAWARE
STAFFORD, DO, DOUGLAS T	MONTGOMERY
STAFFORD, MD, REGIS W	ALLEGHENY
STAHLMAN, MD, FREDERICK B	CLARION
STAHLMAN, MD, ROY A	DELAWARE
STAHLNECKER, MD, C STEPHEN	DELAWARE
STAINBACK, MD, WILLIAM C	MONTGOMERY
STALTER, MD, RALPH J	ALLEGHENY
STALTERI, DO, MICHAEL F	INDIANA
STAMAN, MD, HARRY	ALLEGHENY
STAMATAKOS, MD, MICHAEL J	LEHIGH
STAMILIO, DAVID M	STUDENT
STAMM, MD, BARRY D	ERIE
STAMPFER, DAVID S	STUDENT
STANCOMBE, MD, WESLEY R	NORTHAMPTON
STANDLER, MD, NANCY A	ALLEGHENY
STANEK, MD, MARJORIE A	PHILADELPHIA
STANEK, MD, ROBERT	PHILADELPHIA
STANGER, MD, ROBERT H	ALLEGHENY
STANISH, MD, FRANK X	ALLEGHENY
STANISLAW, SCOTT R	STUDENT
STANKIEWICZ, MD, RUSSELL J	UNION
STANKO, MD, KENNETH M	ALLEGHENY
STANKOSKI, MD, JOHN A	LUZERNE
STANKOVIC, MD, LJUBISA	DAUPHIN
STANTON, MD, ELIZABETH L	BERKS
STANTON JR, MD, JAMES N	ALLEGHENY
STANTON JR, MD, JOHN J	PHILADELPHIA
STANULONIS, MD, STANLEY W	SCHUYLKILL
STANWYCK, MD, T SCOTT	ERIE
STAPFER, MARIA V	STUDENT
STAPLES, MD, HERMAN D	DELAWARE
STAPOR, MD, DAVID J	ALLEGHENY
STAPP, MD, HARRIET L	MONTGOMERY
STAR, MD, ANDREW M	MONTGOMERY
STARER, MD, LARRIMORE J	DELAWARE
STARK, BRIAN J N	STUDENT
STARK, MD, BRUCE I	CHESTER
STARK, JAMIE C	STUDENT
STARKEY, MD, KATHRYN T	ALLEGHENY
STARKEY, MD, RALPH H	MONTOUR
STARR, MD, ROBERT	ALLEGHENY
STARRELS, MD, MICHAEL E	BUCKS
STARRELS, MD, SIDNEY H	PHILADELPHIA
STARZ, MD, TERENCE W	ALLEGHENY
STARZL, MD, THOMAS E	ALLEGHENY
STASIK JR, MD, JOHN J	LEHIGH
STASSI, MD, JOHN	PHILADELPHIA
STATLER, JOHN D	STUDENT
STAUB, MD, ALICE W	PHILADELPHIA
STAUFFER, BRIAN L	STUDENT
STAUFFER, MD, HAROLD E	LANCASTER
STAUFFER, MD, JAMES D	LEBANON
STAUFFER, MD, RICHARD A	NORTHAMPTON
STAUFFER, MD, STANLEY S	NORTHAMPTON
STAVRIDES, MD, ALEXANDER	ALLEGHENY
STAYER, MD, GLENN A	MONTOUR
STEC, MD, EUGENE G	LACKAWANNA
STECKEL, MD, ALAN J	ALLEGHENY
STECKEL, MD, DONALD C	UNION
STEED, MD, DAVID L	ALLEGHENY
STEEL, MD, HOWARD H	PHILADELPHIA
STEELE, MD, JOHN E	CARBON
STEELE, MD, JOHN F	MERCER
STEELE, DO, KIRTH W	NORTHAMPTON
STEELE, MD, LOGAN H	ALLEGHENY
STEEN, MD, C A EDWARD	MONTOUR
STEEN, MD, OLIVER T	ALLEGHENY
STEERMAN, MD, PAUL H	PHILADELPHIA
STEFANELLI, MD, JAMES L	LACKAWANNA
STEFANELLI, MD, JOANN G	ALLEGHENY
STEFANICK, DO, PATTI A	CAMBRIA
STEFANIK, MD, DAVID	CAMBRIA
STEFANOVSKI, MD, NICK	ERIE
STEFANYSZYN, MD, MARY A	PHILADELPHIA
STEFFENSEN, MD, DAVID O	WESTMORELAND
STEGMAN, MD, DANIEL Y	PHILADELPHIA
STEGURA, MD, BARNEY A	LUZERNE
STEIGERWALT, MD, JOHN L	MONTGOMERY
STEIKER, MD, DANIEL D	PHILADELPHIA
STEIN, MD, ALAN H	CAMBRIA
STEIN, MD, ANTHONY	STUDENT
STEIN, MD, ARTHUR V	LEHIGH
STEIN, MD, BRADLEY D	ALLEGHENY
STEIN, MD, DANIEL E	PHILADELPHIA
STEIN, DO, DAVID M	LEHIGH
STEIN, DREW A	STUDENT
STEIN, MD, ELEANOR R	DAUPHIN
STEIN, MD, FRANKLIN M	PHILADELPHIA
STEIN, MD, GEORGE N	PHILADELPHIA
STEIN, MD, HARMON C	BUCKS
STEIN, MD, HYMEN D	PHILADELPHIA
STEIN, MD, IRVIN	PHILADELPHIA
STEIN, DO, JACK M	PHILADELPHIA
STEIN, MD, NATALIO	PHILADELPHIA
STEIN, MD, RICHARD N	NORTHAMPTON
STEIN, MD, ROBERT S	NORTHAMPTON
STEIN, MD, STANLEY I	NORTHAMPTON
STEIN, MD, THOMAS M	ALLEGHENY
STEIN, MD, WALTER	BERKS
STEIN JR, MD, DONALD B	DELAWARE
STEINBERG, MD, ABRAAM	ALLEGHENY
STEINBERG, DAVID M	STUDENT
STEINBERG, MD, MARVIN E	PHILADELPHIA
STEINBERG, MD, MICHAEL L	ALLEGHENY
STEINBERG, MD, NATHAN	PHILADELPHIA
STEINBOOK, MD, MELVIN	NORTHAMPTON
STEINBRINK, MD, WILLIAM H	ERIE
STEINDEL, MD, CARL R	LACKAWANNA
STEINFELD, MD, JOY D	PHILADELPHIA
STEINFELD, MD, RICHARD I	MERCER
STEINFIELD, MD, PAUL H	PHILADELPHIA
STEINGARD, MD, JOSEPH J	PHILADELPHIA
STEINMAN, MD, ARNOLD M	ALLEGHENY
STEINMAN, MD, RICHARD A	ALLEGHENY
STEINMAN, MD, ROBERT C	LANCASTER
STEINMETZ III, MD, CHARLES G	PHILADELPHIA
STEINMEYER JR, MD, HARRY H	MONTGOMERY
STEINOUR, MD, THOMAS A	FRANKLIN
STEKERT, MD, RUTH	BUCKS
STELLA, MD, JOSEPH E	LACKAWANNA
STELMACH, MD, PETER	BERKS
STELMACH, MD, W PETER	BERKS
STELZER, MD, FREDERIC A	LEHIGH
STEM JR, MD, THEODORE B	WESTMORELAND
STEMMLER, MD, EDWARD J	PHILADELPHIA
STEMMLER, MD, MARGARET M	PHILADELPHIA
STEMPKOWSKI JR, MD, JOSEPH J	ALLEGHENY
STEN, MD, JON D	NORTHUMBERLAND
STENBERG, MD, ROBERT G	CAMBRIA
STENCLER, KERRY A	STUDENT
STENE, MD, JOHN K	DAUPHIN
STENGEL, MD, ROBERT J	LANCASTER
STEPANOW, MD, SAMUEL J	ALLEGHENY
STEPANSKY, MD, DAVID W	MONTGOMERY
STEPHAN, MD, THORSTEN	ALLEGHENY
STEPHENS, MD, MARILYN H	CLEARFIELD
STEPHENS JR, MD, HARRY W	LEHIGH
STEPHENSON, MD, JAMES B	CHESTER
STEPHENSON, MD, ORLANDO K	PERRY
STEPHENSON, MD, PATRICIA A B	BUCKS
STEPPACHER, MD, LESTER G	PHILADELPHIA
STEPT, MD, LARRY L	ALLEGHENY
STEPT, MD, LEONARD A	ALLEGHENY
STEPT, MD, RAYMOND	ALLEGHENY
STEPT, MD, WILLIAM J	ALLEGHENY
STERLING, MD, NANCY I	DAUPHIN
STERLING, ROBERT S	STUDENT
STERLING, SCOTT W	STUDENT
STERN, MD, JOHN J	PHILADELPHIA
STERN, MD, LILLIAN H	PHILADELPHIA
STERN, MD, ROBERT M	ALLEGHENY
STERNBURG, MD, JON K	WAYNE/PIKE
STERNLIEB, MD, JONATHAN M	MONTGOMERY
STERNLIEB, MD, SANFORD B	LUZERNE
STETZ, DO, DREW J	HUNTINGDON
STEVEN, MD, JAMES M	PHILADELPHIA
STEVENS, MD, BRYAN J	YORK
STEVENS, DO, PHILIP J	DELAWARE
STEVENS, MD, ROBERT G	LYCOMING
STEVENSON, MD, RICHARD D	MONTGOMERY
STEVER, DO, MICHAEL R	INDIANA
STEWARD, MD, JOANNE A	LEHIGH
STEWARD JR, MD, ROBERT E	CLEARFIELD
STEWART, MD, ELLEN C	ALLEGHENY
STEWART, MD, MERVIN S	ALLEGHENY
STEWART, MD, MICHAEL J	PHILADELPHIA
STEWART, MD, MICHAEL P	LACKAWANNA
STEWART, MD, PATRICIA E	MONTGOMERY
STEWART, MD, RICHARD P	DAUPHIN
STEWART, MD, WILLIAM D	ALLEGHENY
STEWART, MD, WILLIAM P	PHILADELPHIA
STEWART, MD, WILLIAM W	MONTGOMERY
STEWART III, DO, JOSEPH H	FRANKLIN
STEWART JR, MD, WILLIAM G	MONTGOMERY
STICK, MD, WESLEY D	YORK
STIEBER, MD, SCOTT F	LANCASTER
STIEG, MD, PHILIP D	LEBANON
STIEGEL, MD, ROBERT M	BEAVER
STIERSTORFER, MD, MAX J	LEHIGH
STIFFEL, MD, ARTHUR	PHILADELPHIA
STIFFEL, MD, JERRY	PHILADELPHIA
STILE, MD, SABATO A	WESTMORELAND
STILLE, MD, CHRISTOPHER J	PHILADELPHIA
STINE, MD, AMY R	ALLEGHENY
STINE, MD, ANN M	ALLEGHENY
STINE JR, MD, LESTER E	ALLEGHENY
STINELY, MD, REGIS W	WASHINGTON
STINEMAN, MD, MARGARET G	PHILADELPHIA
STISH, MD, EUGENE R	LUZERNE
STISH JR, MD, ANTHONY G	LUZERNE
STITT, MD, DONALD G	MERCER
STOCK, DO, THOMAS C	YORK
STOCKER, MD, KEVIN D	ALLEGHENY
STOCKSTILL, MD, TODD F	ALLEGHENY
STODDARD, MD, NEIL W	LEHIGH
STOKAR, MD, LAWRENCE M	ALLEGHENY
STOKEN, MD, DREW J	CUMBERLAND
STOKER, MD, JOHN W	BLAIR
STOKES, MD, LOUIS C	CHESTER
STOKES, MD, RANJAN	PHILADELPHIA
STOLLER, MD, RONALD G	ALLEGHENY
STOLLSTEIMER, MD, GEORGE T	MONTGOMERY
STOLOFF, MD, IRWIN L	PHILADELPHIA
STOLTZFUS, MD, BONNIE M	PHILADELPHIA
STOLTZFUS, MD, ELAM R	UNION
STOLZ, MD, JOHN C	BERKS
STOLZ, MD, JONATHAN L	BERKS
STOLZ, MD, PAUL K	BERKS
STOLZ, DO, RALPH E	LEHIGH
STOLZER, MD, BERTRAND L	ALLEGHENY
STONE, MD, CHERYLE A	WYOMING
STONE, MD, DAVID A	YORK
STONE, MD, DAVID A	ALLEGHENY
STONE, MD, DEBORAH L	ALLEGHENY
STONE, DO, DONALD J	COLUMBIA
STONE, MD, GWEN E	PHILADELPHIA
STONE, MD, HRANT H	PHILADELPHIA
STONE, JEFFREY D	STUDENT
STONE, MD, KENNETH R	PHILADELPHIA
STONE, MD, ROBERT K	MONTGOMERY
STONE, MD, WALKER H	LYCOMING
STONE JR, MD, CHARLES S	ALLEGHENY
STONER, MD, JOHN C	DAUPHIN
STONER, MD, JOHN G	YORK
STONER, MD, MAX A	DAUPHIN
STONER, MD, PAUL S	DAUPHIN
STONER, MD, ROBERT E	LANCASTER
STONER JR, MD, ROBERT R	DAUPHIN
STOOL, MD, SYLVAN E	ALLEGHENY
STOOPS, MELISSA J	STUDENT
STORM, MD, CHARLES T	DELAWARE
STORY, MD, NANCY S	LYCOMING
STOTE, MD, ROBERT M	PHILADELPHIA
STOTLER, MD, CHARLES W	CAMBRIA
STOUDT, MD, DONALD E	BERKS
STOUDT, MD, K DONALD	MERCER
STOUDT, DO, KATHY J	BERKS
STOUFFER JR, MD, VANCE R	YORK
STOUT, MD, RICHARD R	ALLEGHENY
STOUT, MD, WILLIAM J	LANCASTER
STOVER, MD, DONALD L	CAMBRIA
STOWELL, MD, JOSEPH M	BLAIR
STRACCI, DO, PETER F	ALLEGHENY
STRAKA, MD, JOHN A	ALLEGHENY
STRALEY, MD, RICHARD K	LYCOMING
STRAMAT, MD, JOHN M	ALLEGHENY
STRANG, MD, CLYDE A	YORK
STRANG, MD, DAVID J	LUZERNE
STRANG, MD, JOHN E	MONTGOMERY
STRANGARITY, MD, JOSEPH W	LANCASTER
STRATIS, MD, JOHN P	DAUPHIN
STRATTON, MD, HENRY A	PHILADELPHIA
STRATTON, MD, ROBERT D	ERIE
STRATTON, MD, ROBERT G	LEHIGH
STRAUB, MD, WILLIAM H	ALLEGHENY
STRAUBAUGH, MD, JANET T	YORK
STRAUBAUGH, MD, RICHARD	YORK
STRAUSE JR, MD, HAROLD L	BERKS
STRAUSS, DO, CLIFFORD S	DELAWARE
STRAUSS, MD, JAY E	NORTHAMPTON
STRAUSS, MD, RICHARD E	BUCKS
STRAUSS, MD, ROBERT D	LEHIGH
STRAVINO, MD, VINCENT D	NORTHAMPTON
STRAYER, MD, DAVID R	PHILADELPHIA
STRAZEK, MD, LESLAW M	ERIE
STREET, MD, DAVID F	MONTOUR
STREET, MD, THOMAS F	LUZERNE
STREIFF, MD, KATRINA	PHILADELPHIA
STREIFF JR, MD, JOHN J	ERIE
STREISFELD, MD, DAVID L	LEBANON
STREISFELD, MD, NEIL T	PHILADELPHIA
STRELEC, MD, STEPHEN R	ALLEGHENY
STREMPLE, MD, JOHN F	ALLEGHENY
STRENGE, MD, HENRY J	PHILADELPHIA
STRENIO, MD, JONATHAN S	ALLEGHENY
STRETTON, MD, JEAN B	CHESTER
STREUBERT, MD, GEORGE E	NORTHAMPTON
STRIAR, MD, JEFFREY H	MONTGOMERY
STRICKER, MD, ROBERT S	LUZERNE
STRICKLAND, MD, MARY L	MONTOUR
STRICKLER, MD, JANE A M	CENTRE
STRIMLAN, MD, C VAUGHN	ALLEGHENY
STRINE, MD, JAMES A	ALLEGHENY
STRITE JR, MD, JAMES A	FRANKLIN
STRITTMATTER, MD, JOHN M	LANCASTER
STROBBE, MD, RICHARD D	YORK
STROBEL JR, MD, GEORGE E	BERKS
STROCK, MD, BRADFORD K	DAUPHIN
STROCKBINE, MD, MELVIN F	YORK
STROHLEIN, MD, STEPHEN S	MONROE
STRONG, MD, GEORGE H	PHILADELPHIA
STRONG, MD, JANET L	YORK
STRONG, MD, THERESSA B	ALLEGHENY
STRONG III, MD, MICHAEL D	PHILADELPHIA
STRONY JR, RONALD S	STUDENT
STROTHER, MD, GEORGE W	CAMBRIA
STROUD, MD, HILARY A	ALLEGHENY
STROUD, JOAN A	STUDENT
STROWHOUER, DO, WILLIAM J	DELAWARE
STRUMIA, MD, PAUL V	MONTGOMERY
STRUMPH, MD, PAUL S	ALLEGHENY
STRUNK, MD, THOMAS J	CAMBRIA
STRUNK, MD, WILLIAM M	NORTHAMPTON
STRYKER, MD, ALLAN K	LYCOMING
STRZELECKI, MD, ZIGMUND F	BUCKS
STUART, MD, JOHN A	ALLEGHENY
STUART, MD, JOHN C	ALLEGHENY
STUART, PETER J	STUDENT
STUART, MD, THOMAS J	LANCASTER
STUART, EXEC SEC, MD, ROBERT B	ERIE
STUBA, MD, STELLA	MONTGOMERY
STUBBS, MD, G WINSTON	PHILADELPHIA
STUCCIO, MD, DOMINICK A	LUZERNE
STUCCIO, MD, JOSEPH J	LUZERNE
STUDDERT, DAVID S	STUDENT
STUDDIFORD, MD, JAMES S	PHILADELPHIA
STUGAN, ANTHONY J	STUDENT
STULL, MD, MARK W	LANCASTER
STULL, MD, TODD E	BLAIR
STUMPF, MD, REBECCA L	ALLEGHENY
STUPI, MD, ANGELA M	ALLEGHENY
STUPNIKER, MD, SONIA	PHILADELPHIA
STURM, MD, PATRICK W	BEAVER
STURM JR, MD, CHARLES F	ALLEGHENY
STUTMAN, MD, FRED A	PHILADELPHIA
STUTZ, MD, MARTIN	WASHINGTON
STUZIN, NINA E	STUDENT
STYLER, MD, MICHAEL J	PHILADELPHIA
STYPULA, MD, MARK O	ALLEGHENY
STYPULA, MD, RICHARD W	MERCER
SU, MD, LANG-PAO	LACKAWANNA
SU, SEAN	STUDENT
SU, MD, SHYH-MIN	ALLEGHENY
SUAREZ, MD, MILITZA E	LUZERNE
SUAREZ, MD, RAMON U	LEBANON
SUATONI JR, MD, FRANK J	ALLEGHENY
SUBBIAH, MD, THEUARAYA N	BUTLER
SUBRAMANY, MD, NARAYANASWAMY	ELK/CAMERON
SUCATO, GINA S	STUDENT
SUERO, MD, RENE OSCAR	PHILADELPHIA
SUFIT, MD, SUSAN D	WASHINGTON
SUGAR, MD, MIKLOS	DELAWARE
SUGARMAN, MD, SAMUEL	PHILADELPHIA
SUGDEN, MD, WILLIAM A	BUCKS
SUGIURA, MD, SUMIKO M	PHILADELPHIA
SUH, DAVID B	STUDENT
SUH, MD, SANG J	LACKAWANNA
SUH, MD, YOO T	PHILADELPHIA
SUK, MD, JIN H	VENANGO
SUKANICH, MD, AURAPIN C	ALLEGHENY
SUKANICH, MD, KRIENGSAK	ALLEGHENY
SUKAROCHANA, MD, KAMTHORN	ALLEGHENY
SUKERKAR, MD, NITEEN N	FRANKLIN
SUKOVICH, WILLIAM	STUDENT
SUKYS, MD, NANCY A	ALLEGHENY
SUL, JAMES H	STUDENT
SULECKI, MD, MATTHEW G	WESTMORELAND
SULEWSKI, MD, MICHAEL E	PHILADELPHIA
SULLIVAN, MD, EDWARD M	DELAWARE
SULLIVAN, MD, JOHN M	DAUPHIN
SULLIVAN, MD, LAWRENCE X	ALLEGHENY
SULLIVAN, MD, MICHAEL T	CLEARFIELD
SULLIVAN, MD, MICHAEL W	PHILADELPHIA
SULLIVAN, MD, RICHARD A	MONTGOMERY
SULLIVAN, MD, ROBERT D	BLAIR
SULLIVAN, MD, TIMOTHY M	BRADFORD
SULLIVAN, MD, WILLIAM A	DAUPHIN
SULLIVAN, MD, WILLIAM H	PHILADELPHIA
SULLIVAN JR, MD, LAWRENCE X	ALLEGHENY
SULLIVAN JR, MD, THEODORE R	MONTGOMERY
SULLUM, MD, JONATHAN C	LACKAWANNA
SULTZ, DO, MARVIN E	PHILADELPHIA
SUMKIN, DO, JULES H	ALLEGHENY
SUMMERS, MD, JANE M	PHILADELPHIA
SUMMERS, MD, KERMIT L	LANCASTER
SUMMERS, MD, SHANE O	ALLEGHENY
SUMMERTON, MD, SUSAN L	PHILADELPHIA
SUMMONS, MD, HOWARD J	BERKS
SUMNER, MD, ANDREW D	DAUPHIN
SUMNER, MD, ANNE E	PHILADELPHIA
SUN, MD, DANNY D	NORTHAMPTON
SUN, MD, ELIZABETH A	MONTGOMERY
SUN, MD, EVELYN L	PHILADELPHIA
SUN, MD, WILLIAM Z	PHILADELPHIA
SUNBY, MD, CARL R	CRAWFORD
SUNDERLIN JR, MD, FREDERICK S	MONTOUR
SUNDERMAN, MD, F WILLIAM	PHILADELPHIA
SUNDHEIM, MD, JAMES L	LACKAWANNA
SUNDT, MD, LINDA M	DELAWARE
SUNG, MD, CHUN M	ALLEGHENY
SUNG, MD, DUK I	ALLEGHENY
SUNG, MD, LEE H	WESTMORELAND
SUNG, MD, PAUL P	LAWRENCE
SUPER, MD, LEONID E	PHILADELPHIA
SUPERDOCK, MD, DAVID T	LANCASTER
SUPINSKI, MD, ROBERT S	POTTER
SUPPA, MD, OSVALDO S	ERIE
SUPPLE, MD, EDWARD W	LANCASTER
SUPROCK, MD, MARK D	ERIE
SURACI, MD, ALDO J	COLUMBIA
SURKIN, MD, MARC I	DELAWARE
SURMELI, SEDAT M	STUDENT
SUSANG-TALAMO, MD, BARBARA A	ALLEGHENY
SUSANN, MD, PHILIP W	ERIE
SUSI, MD, JOSEPH A	ERIE
SUSKI, DAVID A	STUDENT
SUSSMAN, MD, DAVID	LEHIGH
SUSSMAN, MD, MARCEL S	PHILADELPHIA
SUSSMAN, DO, MARK P	MONTGOMERY
SUSSMAN, MD, NATHAN	DAUPHIN
SUSSMAN, MD, SYLVIA	LEHIGH
SUTER, MD, HARRY J	LYCOMING
SUTER, MD, STANLEY C	LEBANON
SUTHAR, MD, ARVIND L	MIFFLIN/JUNI
SUTHERLAND, MD, ROBERT D	BERKS
SUTLIFF, MD, CARLENE S	DAUPHIN
SUTLIFF, MD, FREDERICK P	MONTGOMERY
SUTNICK, MD, ALTON I	PHILADELPHIA
SUTPHEN, MD, DIANA L	NORTHAMPTON
SUTTER, DO, FRANCIS P	PHILADELPHIA
SUTTON, MD, A KEITH	HUNTINGDON
SUTTON, MD, CHARLES A	BLAIR
SUTTON, MD, DIANE G	MERCER

SUTTON, MD, PAUL L	MONTOUR
SUTTON, MD, ROBERT L	ALLEGHENY
SUTTON JR, MD, EDWARD L	BUTLER
SUTTON JR, MD, JOHN C	BEAVER
SUVARNAKAR, MD, JAWAHAR N	JEFFERSON
SUWAN, MD, NIPAPAN	ARMSTRONG
SUWAN, MD, SAKDIDEJ	ARMSTRONG
SVETEC, DAVID A	STUDENT
SVIGALS, MD, PAUL J	PHILADELPHIA
SWAAB, MD, RONALD L	PHILADELPHIA
SWACKHAMMER, MD, RANDY L	WESTMORELAND
SWAGLER, DO, CURTIS P	TIOGA
SWAIN, MD, ASHA L	BLAIR
SWAIN, MD, STEPHEN S	SCHUYLKILL
SWALLOW, DO, WILLIAM S	UNION
SWAMI, MD, KUMAR	PHILADELPHIA
SWAMIDOSS, MD, STEPHENSON S	DAUPHIN
SWAMY, MD, MALLIKARJUNA S	ALLEGHENY
SWAN, MD, BARBARA E	ALLEGHENY
SWAN, MD, DAVID M	ALLEGHENY
SWANAY, RUTH S	STUDENT
SWANK, MD, MARK D	NORTHAMPTON
SWANSIGER, MD, BRIAN J	ALLEGHENY
SWANSIGER, MD, ROBERT J	CAMBRIA
SWANSON, MD, LEE A	ALLEGHENY
SWANSON, MD, MICHAEL D	ALLEGHENY
SWANTEK, DO, LEO J	ERIE
SWARTZ, MD, EDWARD F	FRANKLIN
SWARTZ, MD, JOEL D	PHILADELPHIA
SWARTZ, MD, MARK A	FRANKLIN
SWARTZ, MD, STAN H	LYCOMING
SWARTZ, MD, WILLIAM M	ALLEGHENY
SWARUP, MONTE R	STUDENT
SWAUGER, JUDITH A	STUDENT
SWEENEY, DO, DONALD J	TIOGA
SWEENEY, DO, THOMAS F	YORK
SWEET, MD, WILLIAM A	BERKS
SWEGAL, MD, OTTO F	ALLEGHENY
SWEIGARD, MD, KEITH W	MONTGOMERY
SWENSEN, MD, HAROLD E	ALLEGHENY
SWENSEN, MD, NANCY M	ALLEGHENY
SWENSON, MD, DAVID L	BUTLER
SWETERLITSCH, MD, LOUIS H	NORTHAMPTON
SWETERLITSCH, MD, PAUL R	BRADFORD
SWICK II, MD, J HOWARD	BEAVER
SWIDWA, MD, DENISE M	ALLEGHENY
SWIERCZEWSKI, MD, EDWARD V	WESTMORELAND
SWIFT, MD, FRANK L	LACKAWANNA
SWIFT, IAN R	STUDENT
SWIFT, MD, SARAH E	STUDENT
SWISHER II, MD, CHARLES L	LACKAWANNA
SWITALA, REGIS T	STUDENT
SWITZER, MD, GARY L	VENANGO
SYBING, MD, EUGENIO A	MERCER
SYBING, MD, MELITA M	MERCER
SYED, MD, TASNEEM A Z	WASHINGTON
SYKES, DO, LEROY I	DAUPHIN
SYKES JR, MD, NORMAN L	STUDENT
SYLVESTER, ALFRED P	STUDENT
SYLVESTRI, MD, GEORGE M	DAUPHIN
SYMS, MD, CHARLES A	PHILADELPHIA
SYNN, FLORENCE J	STUDENT
SYROP, TAMA L	STUDENT
SYROPOULOS, MD, HEIDI J	CENTRE
SZABO, MD, EDWARD T	WESTMORELAND
SZABO, MD, EMIL R	HUNTINGDON
SZABO, MD, FERDINAND F	COLUMBIA
SZABO, MD, PATRICIA E	DELAWARE
SZABO, MD, RUDOLPH G	COLUMBIA
SZACHNOWSKA, MD, BARBARA M	PHILADELPHIA
SZAFRANSKI, MD, JOHN A	STUDENT
SZAL, MD, JOSEPH J	PHILADELPHIA
SZALADOS, MD, JAMES E	PHILADELPHIA
SZARKO, MD, CAROL J	BERKS
SZARKO, MD, FRANK J	BERKS
SZARKO, MD, RICHARD J	LANCASTER
SZAWALUK, MD, JOHN J	ALLEGHENY
SZAYNA, MD, STANLEY	PHILADELPHIA
SZENICS, MD, JONATHAN M	LEHIGH
SZOKE, MD, EDWARD E	ADAMS
SZUSTAK, DO, JOSEPH J	LUZERNE
SZUTOWICZ, DO, MICHAEL P	LANCASTER
SZYDLOWSKI, MD, THADDEUS R	LEBANON

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TABACHNICK, MD, THEODORE M	ALLEGHENY
TABAS, MD, GARY	ALLEGHENY
TABAS, MD, JANET H	ALLEGHENY
TABB, MD, DAVID R	YORK
TABOR, MD, ELLEN K	ALLEGHENY
TABUENA, MD, AMELIA L	MONTGOMERY
TACHDJIAN, MD, VAHAKEN	PHILADELPHIA
TACHOVSKY, MD, THOMAS J	NORTHAMPTON
TADA, MD, NAOTO	ALLEGHENY
TADDONIO, MD, WILLIAM S	CHESTER
TADJALLI, MD, HELEN E	YORK
TADLEY, DO, GERALD	PHILADELPHIA
TAEKMAN, MD, JEFFREY M	DAUPHIN
TAFFLIN, DO, DENNIS H	BUCKS
TAFTAF, MD, MOHAMMAD O	LAWRENCE
TAGALA, MD, PRAXIDIO H	CLEARFIELD
TAGGART, MD, GEORGE W	LUZERNE
TAGGART, MD, JAMES D	CUMBERLAND
TAGHIZADEH, MD, FIROOZ	FAYETTE
TAHIR, MD, MAHMOD A	LEHIGH
TAI, LISA H	STUDENT
TAIT, MD, EDWIN C	MONTGOMERY
TAITELBAUM, MD, BEN	ALLEGHENY
TAKACH, MD, STEPHEN J	INDIANA
TAKEDA, MD, MIBAO	PHILADELPHIA
TALAGA, MD, RONALD N	WAYNE/PIKE
TALAMO, MD, ROBERT J	MONTGOMERY
TALANGBAYAN, MD, FRANCIS V	PHILADELPHIA
TALATI, MD, DINESHKUMAR C	LUZERNE
TALBERT, MD, MADONNA L	LANCASTER
TALBOT, MD, SHERYL F	PHILADELPHIA
TALBOTT, MD, JOHN B	ALLEGHENY
TALLERICO, MD, SAMUEL J	ALLEGHENY
TALLICK, SUSAN A	STUDENT
TALLMAN, MD, EDWIN H	BERKS
TALLUTO, MD, DONNA M	STUDENT
TALSANIA, MD, JAY S	PHILADELPHIA
TAMA, MD, LAWRENCE	BRADFORD
TAMA, MD, LAWRENCE E	TIOGA
TAMAKI, MD, H TOM	MONTGOMERY
TAMBURRO, DO, VALERIE L	DELAWARE
TAN, MD, ANTHONY H	ALLEGHENY
TAN, MD, ANTONIUS H	LEHIGH
TAN, MD, DOMINGO C	CLEARFIELD
TAN, MD, EDWIN L	CAMBRIA
TAN, MD, ISABEL G	MERCER
TAN, MD, JOSEPHINE C	PHILADELPHIA
TAN, MD, LIAN K	CARBON
TAN, MD, MYRNA M	PHILADELPHIA
TAN, MD, WILFREDO S	ERIE
TAN, MD, YOKE Y	DAUPHIN
TAN JR, MD, RAMON N	CAMBRIA
TANANIS, MD, LEONARD J	SCHUYLKILL
TANG, GEOFFREY R	STUDENT
TANNEHILL, MD, NORMAN S	ALLEGHENY
TANNENBAUM, MD, DAVID S	MONTGOMERY
TANNER, MD, JONATHAN W	STUDENT
TANNER, MD, LEONARD M	LEBANON
TANNING, MD, HOWARD M	ALLEGHENY
TANTISIRA, MD, SOMPHONG	WESTMORELAND
TANTUM, MD, KERMIT R	DAUPHIN
TANYOL, MD, HASIB	MONTGOMERY
TANZER, MD, PETER P	ALLEGHENY
TAPYRIK, MD, NICHOLAS	BEAVER
TARABISHI, MD, FARIDA NASR	ALLEGHENY
TARAS, MD, JOHN S	PHILADELPHIA
TARASZEWSKI, MD, ROBERT	MONTOUR
TARGUM, MD, STEVEN D	DELAWARE
TAROLI, MD, ANDREA C	LUZERNE
TART JR, MD, BRASTON I	YORK
TARWATER, MD, DOYLE L	WASHINGTON
TASE, MD, DOUGLAS S	BERKS
TASHMAN, DAVID A	STUDENT
TASMAN, MD, WILLIAM S	PHILADELPHIA
TASSONE, ROSALIE F	STUDENT
TATARKO, MD, MICHAEL	CAMBRIA
TATE, MD, DAVID J	ALLEGHENY
TATE, MD, FREDERICK J	LEHIGH
TATEM III, MD, HENRY R	BUCKS
TATRO, MD, JEFFREY A	DAUPHIN
TATTERSALL, MD, HAROLD A	MONROE
TATU, MD, WILLIAM F	MONROE
TATUM, MD, JAMES K	BEAVER
TAUBER, MD, JOSEPH B	ALLEGHENY
TAUBERG, MD, HERBERT R	ALLEGHENY
TAUBERG, MD, STUART G	ALLEGHENY
TAUS, DO, JOHN K	LEHIGH
TAUSCH, MD, GILBERT S	MONTGOMERY
TAVANA, MD, MANOUCHER	ERIE
TAVANI, DO, DEEBEANNE M	PHILADELPHIA
TAVARES, MD, JOAO O	ERIE
TAVARES, MD, JOSEPH F	NORTHMBRLAND
TAVARIA, MD, SOLI	SCHUYLKILL
TAVILL, MD, MICHAEL A	PHILADELPHIA
TAX, MD, RICHARD L	BUCKS
TAXIN, MD, RICHARD N	DELAWARE
TAYLOR, MD, ARTHUR R	LYCOMING
TAYLOR, MD, BRIAN T	FAYETTE
TAYLOR, MD, DEBRA D	CUMBERLAND
TAYLOR, MD, JAMES A	MONROE
TAYLOR, MD, JAMES E	PHILADELPHIA
TAYLOR, MD, JEFFREY S	MONROE
TAYLOR, MD, MARCIA R	PHILADELPHIA
TAYLOR, MD, MARK A	BLAIR
TAYLOR, MD, MEGAN B	MONTGOMERY
TAYLOR, PAULA R	STUDENT
TAYLOR, MD, PHILIP C	PHILADELPHIA
TAYLOR, MD, SHARON L	ALLEGHENY
TAYLOR, MD, SUSAN C	PHILADELPHIA
TAYLOR, MD, THOAMS J	FRANKLIN
TAYLOR III, MD, JAMES S	DAUPHIN
TAYLOR JR, MD, GRANT E	PHILADELPHIA
TAYLOR-TYREE, MD, GILL M	ADAMS
TCHONG, MD, KUO-LIANG	DELAWARE
TE, MD, TOMAS T	BUCKS
TEANO, MD, DAN A	DELAWARE
TECCE, MD, MARC A	PHILADELPHIA
TEDESCHI, MD, MICHELE T	STUDENT
TEDESCO, DO, J MICHAEL	LUZERNE
TEDESCO, DO, JOHN A	ERIE
TEEHAN, MD, BRENDAN P	MONTGOMERY
TEEPLE JR, MD, EDWARD	ALLEGHENY
TEET, MD, DANIEL A	WESTMORELAND
TEETER, MD, JAMES H	FRANKLIN
TEGELER, MD, JAMES A	YORK
TEGZES JR, MD, GEORGE	ALLEGHENY
TEH, MD, PEK C	LAWRENCE
TEICH, MD, STEPHEN M	MONTGOMERY
TEICHMAN, MD, FRED	UNION
TEITELBAUM, MD, CARL	LUZERNE
TEJPAR, MD, MOHAMED K	LAWRENCE
TEMELES, MD, LAWRENCE	PHILADELPHIA
TEMELES, MD, ROY S	ALLEGHENY
TEMPLE, MD, ANTHONY R	CHESTER
TEMPLETON, MD, BRYCE	PHILADELPHIA
TEMPLETON, MD, JOSEPHINE J	PHILADELPHIA
TEMPLETON III, MD, JOHN Y	PHILADELPHIA
TEMPLETON JR, MD, JOHN M	PHILADELPHIA
TENAGLIA, MD, NICHOLAS C	MONTGOMERY
TENDLER, MD, STEVEN W	MONTGOMERY
TENEDIOS, MD, GEORGE	MONTOUR
TENENOUSER, MD, BARRY	ALLEGHENY
TENICELA, MD, RUBEN	ALLEGHENY
TENSUAN JR, MD, LEONARDO S	SOMERSET
TEODORO, MD, JOSE V	CAMBRIA
TEOPENGCO, MD, LUIS T	ALLEGHENY
TEPE, MD, PAUL G	ALLEGHENY
TEPLICK, MD, J GEORGE	PHILADELPHIA
TEPLIS, MD, ALAN C	DAUPHIN
TEPPER, MD, MAURICE C	PHILADELPHIA
TEPPER, MD, RICHARD L	PHILADELPHIA
TEREDESAI, MD, PRADIP R	ALLEGHENY
TERHAAR, DO, PETER J	COLUMBIA
TERMINI, MD, JOSEPH T	LEHIGH
TERNER, MD, IRWIN S	ALLEGHENY
TERNES, MD, ROBERT J	FRANKLIN
TERRY, CHARLES M	STUDENT
TERSAK, JEAN M	STUDENT
TERWILLIGER, MD, JERRY W	BRADFORD
TERZIAN, MD, ALLEN E	DELAWARE
TESORIERO, LAURA M	STUDENT
TESSARO, MD, ANNE N	ALLEGHENY
TESSLER, MD, A ROBERT	PHILADELPHIA
TESTA, MD, JOSEPH A	WESTMORELAND
TESTA, DO, MARK A	PHILADELPHIA
TESTER, MD, WILLIAM J	PHILADELPHIA
TETRICK, MD, ELBERT L	ALLEGHENY
TEUFEL, MD, SEVERIN	MONTGOMERY
TEY, MD, PETER H	CARBON
THAETE, MD, F LELAND	ALLEGHENY
THAI, NGOC L	STUDENT
THAKARAR, MD, PUSHPA	CHESTER
THAL, MD, IRA M	PHILADELPHIA
THALER, MD, ERICA R	PHILADELPHIA
THAMES, DO, RICHARD	JEFFERSON
THANE, MD, THANE T	FRANKLIN
THANKI, MD, ASHOKKUMAR S	BUCKS
THASE, MD, MICHAEL E	ALLEGHENY
THATCHER, MD, JEFFREY D	BUCKS
THEERAKULSTIT, MD, VIRACHAI	ALLEGHENY
THEIS, MD, STEVEN W	ALLEGHENY
THEL JR, MD, HENRY C	BEAVER
THEMAN, MD, TERRILL E	NORTHAMPTON
THEOBALD, MD, MICHAEL R	ALLEGHENY
THEODORAN, DO, CHRIS G	LANCASTER
THETGYI, MD, KATHERINE	PHILADELPHIA
THEURKAUF JR, MD, EDWARD A	CHESTER
THIELE, MD, BRIAN L	DAUPHIN
THIMONS, MD, JOSEPH A	ALLEGHENY
THODER, MD, JOSEPH J	PHILADELPHIA
THOFT, MD, RICHARD A	ALLEGHENY
THOMAS, MD, ALEX T	LEHIGH
THOMAS, MD, ANDREW W	ALLEGHENY
THOMAS, MD, BRUCE L	HUNTINGDON
THOMAS, MD, CARMEN C	PHILADELPHIA
THOMAS, DO, CHARLES E	YORK
THOMAS, MD, CHESTER G	DAUPHIN
THOMAS, MD, CHRISTOPHER W	CRAWFORD
THOMAS, DO, DAVID A	DELAWARE
THOMAS, MD, DAVID E	ALLEGHENY
THOMAS, MD, F ARDELL	TIOGA
THOMAS, MD, GARY R	PHILADELPHIA
THOMAS, DO, GARY S	CAMBRIA
THOMAS, MD, GEORGE P	CARBON
THOMAS, MD, HAROLD D	WASHINGTON
THOMAS, MD, HARRY L	PHILADELPHIA
THOMAS, MD, HENRY W	ALLEGHENY
THOMAS, HOLLY J	STUDENT
THOMAS, MD, JAMES H	WESTMORELAND
THOMAS, MD, JOHN M	BRADFORD
THOMAS, MD, JOHN W	ALLEGHENY
THOMAS, MD, JOSEPH M	ERIE
THOMAS, MD, L MARTHA ANN	YORK
THOMAS, MD, LISA C	ALLEGHENY
THOMAS, MD, LYNDA T	PHILADELPHIA
THOMAS, MD, NATHAN O	SOMERSET
THOMAS, MD, ROBERT D	ALLEGHENY
THOMAS, MD, RONALD L	ALLEGHENY
THOMAS, MD, SHERY	ALLEGHENY
THOMAS, STEPHEN J	STUDENT
THOMAS, MD, TERRENCE J	SOMERSET
THOMAS, MD, VICTOR J	ALLEGHENY
THOMAS, MD, WILLIAM E	MERCER
THOMAS JR, MD, DAVID W	CLINTON
THOMAS JR, MD, HOWARD P	BUCKS
THOMAS JR, MD, JAMES A	DELAWARE
THOMAS JR, MD, JAMES J	ERIE
THOMAS JR, MD, JOHN W	PHILADELPHIA
THOMAS JR, MD, ROBERT F	BERKS
THOME, DO, DONALD H	MIFFLIN/JUNI
THOMPSON, ANN-MARIE S	STUDENT
THOMPSON, MD, BRADFORD R	BEAVER
THOMPSON, MD, C FRED	NORTHAMPTON
THOMPSON, MD, CAREN L	PHILADELPHIA
THOMPSON, MD, CARSON J	LACKAWANNA
THOMPSON, MD, DAN R	ALLEGHENY
THOMPSON, MD, DAVID I	CUMBERLAND
THOMPSON, MD, GREGORY M	CHESTER
THOMPSON, MD, HERBERT	ALLEGHENY
THOMPSON, MD, JAMES W	MONTGOMERY
THOMPSON, DO, JEFFREY N	ALLEGHENY
THOMPSON, MD, JOHN W	JEFFERSON
THOMPSON, MD, LINDA G	BEAVER
THOMPSON, MD, MARCIA L	ALLEGHENY
THOMPSON, MD, MARK E	ALLEGHENY
THOMPSON, MD, PATREECE M	PHILADELPHIA
THOMPSON, MD, PETER J	VENANGO
THOMPSON, MD, ROBERT J	LEHIGH
THOMPSON, MD, ROBERT L	ALLEGHENY
THOMPSON, MD, ROBERT L	CUMBERLAND
THOMPSON, TODD P	STUDENT
THOMPSON, MD, VIRGIL	PHILADELPHIA
THOMPSON, MD, WILLIAM G	ALLEGHENY
THOMPSON, MD, WILLIAM O	ALLEGHENY
THOMPSON, MD, WILLIAM W	ELK/CAMERON
THOMPSON II, MD, TROY L	PHILADELPHIA
THONET, MD, MARCEL A	PHILADELPHIA
THORNSLEY, MD, SUSAN L	DAUPHIN
THORNTON, MD, JOSEPH K	FRANKLIN
THORNTON, MD, REBECCA R	ALLEGHENY
THORNTON III, MD, JAMES J	DELAWARE
THORP, MD, T RAMSEY	PHILADELPHIA
THORSEN JR, MD, WILLIAM B	YORK
THURMAN, MD, JOHN N	DELAWARE
THURSTON, MD, STEPHEN E	MONTOUR
TIBBELS JR, MD, EWING W	BUCKS
TIBBENS, MD, GEORGE F	WASHINGTON
TIBBITTS, MD, JAMES A	LEBANON
TIBERIO, MD, RICHARD A	FAYETTE
TIBURCIO JR, MD, ALBINO F	BUTLER
TICHENOR, MD, PAUL K	ALLEGHENY
TICK, MD, ROBERT C	BLAIR
TICZON, MD, ANDRES R	ALLEGHENY
TIECHE, MD, STEVEN C	MCKEAN
TIEDEKEN III, JOHN J	STUDENT
TIEFF, DO, MICHAEL W	MONROE
TIERNEY, MD, JAMES R	ALLEGHENY
TIETBOHL, MD, RALPH H	BERKS
TIETJEN, MD, GEORGE W	WAYNE/PIKE
TIFFANY, MD, JOHN R	NORTHAMPTON
TIGER, MD, ERIC H	PHILADELPHIA
TIGER, MD, MELVYN E	PHILADELPHIA
TIGHE, MD, DENNIS A	PHILADELPHIA
TIGNOR, MD, RICHARD F	LYCOMING
TILTON, DO, BRUCE R	CHESTER
TILVA, MD, PRAFUL K	NORTHMBRLAND
TIMEK, MD, PATRICIA A	CAMBRIA
TIMENS, MD, LAWRENCE J	CAMBRIA
TIMKO, MD, JOHN V	PHILADELPHIA
TIMMAPURI, MD, AJAZ J	BUCKS
TIMNEY, MD, THOMAS E	VENANGO
TINDALL, MD, DOROTHY D	MONTGOMERY
TINDALL, MD, HERBERT L	LANCASTER
TINDALL, MD, JANICE C	LANCASTER
TING, TRICIA Y	STUDENT
TINIANOW, MD, LLOYD N	LEHIGH
TINNEY JR, MD, WILLIAM S	LANCASTER
TINSLEY, MD, WENDY W	BUCKS
TIONGSON, MD, ELEANOR S	DELAWARE
TIONGSON JR, MD, JOSE G	DELAWARE
TIPPERMAN, MD, RICHARD	PHILADELPHIA
TIPPET, MD, PAUL D	ALLEGHENY
TIPPING, MD, JAMES S	ALLEGHENY
TIPTON, MD, RAYMOND L	VENANGO
TIRACCHIA, MD, JOSEPH	PHILADELPHIA
TIRNEY, SEAN P	STUDENT
TIRUCHELVAM, MD, VARADEVAN	YORK
TISHERMAN, MD, SAMUEL A	ALLEGHENY
TISHERMAN, MD, SAMUEL E	ALLEGHENY
TISNOWER, MD, HERBERT	PHILADELPHIA
TITCHWORTH, MD, ROY L	ALLEGHENY
TITMAN, MD, WILLIAM E	COLUMBIA
TIU, MD, AMANDO S	PHILADELPHIA
TIU, MD, GRISELDA E	MONTGOMERY
TJAUW, TJHI W	STUDENT
TKATCH, MD, LISA S	DAUPHIN
TOAL, MD, THOMAS M	VENANGO
TOBIA, MD, ENIO W	DELAWARE
TOBIAS, MD, RICHARD S	LYCOMING
TOBIASZ, MD, CHRISTOPHER	LYCOMING
TOCKS, MD, JONATHAN B	DAUPHIN
TODARO, MD, SAMUEL R	LACKAWANNA
TODD, MD, JEFFREY S	LEBANON
TODHUNTER, MD, WILLIAM D	LYCOMING
TODHUNTER, MD, WILLIAM J	LYCOMING
TODOROVSKA, MD, ZAGORKA	PHILADELPHIA
TOFF, DO, KENNETH J	LEHIGH
TOKAREK, ROBERT M	STUDENT
TOKARS, MD, ROGER P	ALLEGHENY
TOKIWA, MD, YUMIKO	ALLEGHENY
TOLAN, MD, JEFFREY R	DAUPHIN
TOLAND, MD, JOSEPH C	PHILADELPHIA
TOLAND, MD, JOSEPH J	PHILADELPHIA
TOLAT, MD, PRATIMA R	PHILADELPHIA
TOLEDO, MD, FRANCISCO L	PHILADELPHIA
TOLENTINO, MD, JULIAN C	BUTLER
TOLENTINO, MD, PABLITO L	BUCKS
TOLERICO, PAUL H	STUDENT
TOLHURST, MD, KIRK D	BRADFORD
TOLIS, MD, BASILE D	BLAIR
TOLLETT, MD, CHARLES A	PHILADELPHIA
TOLMAN, MD, LEON M	ARMSTRONG
TOM, MD, CAROL M	MONTGOMERY
TOM, MD, LAWRENCE WC	PHILADELPHIA
TOM, MD, TODD N	CLARION
TOMA, MD, MICHAEL J	PHILADELPHIA
TOMACK, MD, LAWRENCE S	LYCOMING
TOMANY, KEVIN S	STUDENT
TOMARELLI, MD, RAYMOND C	ALLEGHENY
TOMASELLO, MD, DONALD N	PHILADELPHIA
TOMASI, MD, SAMUEL J	BEAVER
TOMASO, HERBERT J	STUDENT
TOMASSO, STEPHANIE J	STUDENT
TOMAYKO JR, MD, JOHN F	ALLEGHENY
TOMAZIC, DO, DAVID R	LACKAWANNA
TOMCI, MD, GEORGE E	WESTMORELAND

TOME, MD, JULIA A	ALLEGHENY
TOMEDI, MD, JOHN R	LUZERNE
TOMEO, MD, MICHAEL	MONTGOMERY
TOMEZSKO, MD, JANET E	LEHIGH
TOMHAVE, MD, ROBERT H	CAMBRIA
TOMLEY, MD, JOHN E	ALLEGHENY
TOMLIN, MD, JOSEPH G	SCHUYLKILL
TOMLINSON, MD, JOHN W	BUCKS
TOMLINSON, MD, JOHN W	DELAWARE
TOMPKINS, MD, H ERNEST	MONTGOMERY
TONDREAU, MD, RODERICK L	PHILADELPHIA
TONEY, MD, DAVID M	WESTMORELAND
TONEY, MD, MELINDA Q	NORTHAMPTON
TONG, MD, DER-LONG	ALLEGHENY
TONG, JOHN T	STUDENT
TONG, JONATHAN L	STUDENT
TONKONOW, MD, BARRY L	BUCKS
TONSEY, MD, HABIB	PHILADELPHIA
TOOMEY, MD, KATHLEEN E	DELAWARE
TOOR, MD, SHAISTA N	ALLEGHENY
TOOZE, MD, FRANK M	ERIE
TOPAL, MD, JEFFREY E	PHILADELPHIA
TOPERZER, MD, BETTY C	ERIE
TOPOLSKY, MD, DAVID LANE	PHILADELPHIA
TOPORCER, MD, MARY B	PHILADELPHIA
TORAYA, CINDY E	STUDENT
TORBAN, MD, CLARA B	PHILADELPHIA
TORCHIA, MD, JOSEPH A	DAUPHIN
TORCHIA, MD, MARY J	ALLEGHENY
TOREKI, MD, WILLIAM	BUCKS
TOREN, MD, PETER C	MONTGOMERY
TORET, MD, MICHEL P	WESTMORELAND
TORI, MD, JOSEPH N	DELAWARE
TORIO, MD, REYNALDO M	WESTMORELAND
TORNETTA, MD, FRANK J	MONTGOMERY
TOROK, MD, FRANK S	WASHINGTON
TORONY, MD, JEANNE A	LUZERNE
TORP, MD, LISA S	DAUPHIN
TORPEY JR, MD, DAVID J	ALLEGHENY
TORPIE, MD, BARBARA A P	PHILADELPHIA
TORRENCE, MD, MICHAEL B	DELAWARE
TORRES, MD, CARLOS P	ALLEGHENY
TORRES, MD, FLORA M	BEDFORD
TORRES, MD, JOSEPH C	STUDENT
TORRES, MD, JULIO E	NORTHAMPTON
TORRES, MD, MARGARITA	PHILADELPHIA
TORRES, MIGUEL A	STUDENT
TORRES, MD, ROBIN G	BEDFORD
TORRES, MD, VICTOR L	PHILADELPHIA
TORRETTI, MD, DENNIS	MONTOUR
TORREY, MD, EDWIN H	YORK
TOSHNIWAL, MD, PRADIP K	NORTHAMPTON
TOSHNIWAL, MD, RENU	NORTHAMPTON
TOSO, MD, GIANFRANCO F	BERKS
TOTINO, MD, JOSEPH A	DELAWARE
TOUB, MD, DAVID B	MONTGOMERY
TOUCH, SUZANNE M	STUDENT
TOUEY, CHARLES V	STUDENT
TOURTELLOTTE, MD, CHARLES D	PHILADELPHIA
TOUSI, MD, ABBAS H	BEDFORD
TOVEY, MD, JAMES E	MONROE
TOWNEND, MD, STEPHEN C	CHESTER
TOWNSEND, MD, JAY A	CUMBERLAND
TOWNSEND, MD, MARK E	ERIE
TRABULSI, MD, L RICHARD	DELAWARE
TRACHTENBERG, MD, LEE A	ALLEGHENY
TRACHTENBERG, MD, WILLIAM M	LEHIGH
TRACY, MD, GERALD P	LACKAWANNA
TRACY, MELISSA J	STUDENT
TRAGER, JONATHAN D	STUDENT
TRAGESER, MD, TIMOTHY C	ERIE
TRAIMAN, MD, RICHARD G	CHESTER
TRAIN, MD, HENRY D	DAUPHIN
TRAINER, MD, PAUL J	ALLEGHENY
TRAJTENBERG, MD, GEORGE A	CHESTER
TRAN, MD, ANH H	ALLEGHENY
TRAN, MD, NEIL N	MONTGOMERY
TRAN, MD, NHO V	PHILADELPHIA
TRAN, MD, TRAN N	CUMBERLAND
TRANOVICH, MD, MARK	FAYETTE
TRANOVICH, MD, MICHAEL A	ALLEGHENY
TRAUM, MD, RONALD E	PHILADELPHIA
TRAUPMAN, MD, ARNOLD F	NORTHAMPTON
TRAUTLEIN, MD, JOSEPH J	DAUPHIN
TRAVALINE, MD, JOHN M	MONTGOMERY
TRAVERS, MD, DANIEL J	WESTMORELAND
TRAVISANO, MD, FRANK J	DAUPHIN
TRECHA, MD, GREGORY T	ALLEGHENY
TREDENNICK, MD, CHARLES N	BUTLER
TREGER, MD, ALBERT	ALLEGHENY
TREIMAN, PHILIP R	STUDENT
TRELLA, JENNIFER M	STUDENT
TRELLIS, MD, EMIL S	ALLEGHENY
TREMBLAY, MD, ERNEST A	DELAWARE
TREMBLAY, MD, GEOFFREY P	DELAWARE
TREMENTOZZI, DANIEL P	STUDENT
TRENTON, DO, WALTER D	SOMERSET
TRESCOT, MD, RONALD E	YORK
TRETTER, DO, MARGARET S	LEHIGH
TREVASKIS, MD, ALLAN E	LEHIGH
TREVI, EXEC DIR, JOHN	PHILADELPHIA
TREXLER, MD, ETHAN L	BERKS
TREZZA, MD, SCOTT A	CHESTER
TRIANA COOPER, MD, LISETTE	PHILADELPHIA
TRIANO, MD, GENE J	DAUPHIN
TRIANTAFYLLOU, MD, STEVEN J	YORK
TRIBBLE, MD, JANA K	NORTHAMPTON
TRIBIT JR, MD, CHARLES B	PHILADELPHIA
TRICHTINGER, MD, MARTIN D	MONTGOMERY
TRIESTER, MD, ARTHUR N	PHILADELPHIA
TRIMMER JR, MD, JOHN H	YORK
TRIMPI, MD, HOWARD D	LEHIGH
TRINH, MD, CHUONG V	MONTGOMERY
TRINH, MARY THUY T	STUDENT
TRINH, MD, PHUONG N	PHILADELPHIA
TRINIDAD, MD, TITO B	CLEARFIELD
TRINKLE, MD, WILMER S	NORTHAMPTON
TRINKLEY, MD, DAVID R	STUDENT
TRIOLO, MD, JOSEPH	DELAWARE
TRIPI, MD, JOSEPH E	ADAMS
TRIPOLI, MD, CHARLES J	WASHINGTON
TRIPOLI, MD, LOUIS C	WASHINGTON
TRISAL, MD, VIJAY K	ALLEGHENY
TRITSCHLER, MD, JOSEPH P	BEAVER
TRIVEDI, MD, GOPALKRISHNA M	MIFFLIN/JUNI
TRIVUS, MD, ROBERT H	ALLEGHENY
TROCKI-VIDELL, DO, CYLA	PHILADELPHIA
TROIANOS, MD, CHRISTOPHER A	ALLEGHENY
TROILO, MD, CAMILLO T	FAYETTE
TROLLINGER, MD, ROBERT J	PHILADELPHIA
TROMBETTA, MD, MARK G	ALLEGHENY
TROMPETER, MD, JOSEPH I	ALLEGHENY
TRONCALE, MD, JOSEPH A	BERKS
TRONCELLITI, MD, A WAYNE	MONTGOMERY
TRONCELLITI, MD, ALFRED E	MONTGOMERY
TRONCELLITI, MD, MANRICO A	MONTGOMERY
TRONCELLITI, MD, MARIO V	PHILADELPHIA
TRONETTI, DO, PAMELA S	ERIE
TRONZO, MD, ROBERT D	ALLEGHENY
TROPEA, JOSEPH N	STUDENT
TROST, MD, JEFFREY T	LANCASTER
TROSTLE, MD, DAVID C	LEBANON
TROSTLE, MD, DOUGLAS R	LEHIGH
TROTTMAN, MD, JENNIFER E	DELAWARE
TROTZKY, MD, MARGRET S	DELAWARE
TROUT, MD, JOHN A	WESTMORELAND
TROUTMAN, MD, HOLMES R	POTTER
TROXEL, MD, RICHARD S	LEHIGH
TROYAN, MD, BARRY E	INDIANA
TRUEX JR, MD, RAYMOND C	BERKS
TRUGLIA, MD, JOSEPH A	CHESTER
TRUITT, MD, GEORGE W	CHESTER
TRUITT JR, MD, R MARSHALL	PHILADELPHIA
TRUJILLO, MD, RENE	WYOMING
TRUMP, MD, BRYCE E	DAUPHIN
TRUONG, MD, NICHOLAS H	PHILADELPHIA
TRUSKY, MD, JEANETTE I	CENTRE
TRUSNOVIC, MD, WILLIAM D	WASHINGTON
TRYBUS JR, MD, ADAM G	BLAIR
TRYON, BRIAN C	STUDENT
TSAI, MD, EDWARD M	INDIANA
TSAI, GEORGE T	STUDENT
TSAI, MD, JER-YUAN	GREENE
TSAI, MD, LI C	PHILADELPHIA
TSAI, MD, MING C	BLAIR
TSAI, PAULUS D	STUDENT
TSAI, MD, YU J	MONTGOMERY
TSAMBASSIS, MD, NICHOLAS A	WASHINGTON
TSE, MD, ROSE L	PHILADELPHIA
TSENG, MD, FRANCIS H	ERIE
TSOUTSOPLIDES, MD, GEORGE C	LUZERNE
TSU, MD, JACQUELYNN L	MONTGOMERY
TSUNG, MD, WEN-HAN	BEAVER
TUAN, MD, BAO-KUEN	PHILADELPHIA
TUCHINDA, MD, JAUT	ALLEGHENY
TUCKER, MD, JAMES N	ALLEGHENY
TUCKER, MD, JEANIANNE	PHILADELPHIA
TUCKER, MD, JON B	ALLEGHENY
TUCKER, PETER J	STUDENT
TUCKER, MD, THOMAS W	CHESTER
TUFFAHA, MD, HANI J	LYCOMING
TUFFIASH, MD, WILLIAM A	LEHIGH
TUKANOWICZ, MD, STANISLAW A	CAMBRIA
TULISZEWSKI, MD, ROBERT M	ADAMS
TULL, MD, JOHN W	YORK
TULLAI, MD, JOHN	DELAWARE
TULLOCK, MD, WILLIAM C	ALLEGHENY
TULLY, MD, VINCENT J	WAYNE/PIKE
TULSKY, MD, EMANUEL G	PHILADELPHIA
TUMAIAN, MD, ARAM	DELAWARE
TUMEN, MD, HENRY J	PHILADELPHIA
TUNICK, MD, STEPHEN E	BEAVER
TUPCHONG, MD, LESLIE	DELAWARE
TURCAN, DO, ELAINE C	LUZERNE
TURCHETTI, MD, EUGENE A	LACKAWANNA
TURCO, MD, PHILLIP J	CAMBRIA
TUREK, MD, PAUL J	PHILADELPHIA
TUREL JR, MD, ANTHONY P	MONTOUR
TURISSINI, MD, THOMAS J	LUZERNE
TURKEWITZ, MD, DAVID	MONTOUR
TURNAMIAN, MD, RICHARD J	UNION
TURNBLACER, MD, CHARLES B	BUTLER
TURNER, DO, CRAIG F	ALLEGHENY
TURNER, MD, DAVID E	PHILADELPHIA
TURNER, MD, JOSEPH	ALLEGHENY
TURNER, MD, MORRIS E	ALLEGHENY
TURNER, MD, OLIVER E	ALLEGHENY
TURNER, PAMELA R	STUDENT
TURNER, MD, RONALD L	BERKS
TURNER, THANE N	STUDENT
TURNER JR, MD, J ELLIS	DELAWARE
TURNQUIST, PAUL E	STUDENT
TUROCK, MD, MICHAEL J	LACKAWANNA
TURSKY, MD, ROSEMARIE J	DAUPHIN
TURTZO, MD, DOUGLAS F	NORTHAMPTON
TURULA, MD, JON B	LANCASTER
TUSHIM, MD, JOSEPH N	BLAIR
TUTTLE, MD, ALFRED	ALLEGHENY
TUTTLE, MD, WILLIAM B	ALLEGHENY
TUZINSKI, MD, JAMES E	LUZERNE
TWAL, MD, SHAFIC Y	INDIANA
TWEDDEL III, MD, GEORGE K	PHILADELPHIA
TWER, MD, ALAN J	MONTGOMERY
TWERSKI, MD, ABRAHAM J	ALLEGHENY
TWIGGAR II, MD, EDWARD V	NORTHMBRLAND
TYLER, MD, JOHN R	LANCASTER
TYLKA-HOFFMAN, MD, ELEANOR M	ALLEGHENY
TYMOCZKO, MD, ROBERT G	WESTMORELAND
TYMON, MD, TIMOTHY P	LANCASTER
TYNDALL, MD, CHRISTINE S	ALLEGHENY
TYNDALL, MD, JAMES A	DAUPHIN
TYSON, MD, R ROBERT	PHILADELPHIA
TYSON, MD, SCOTT L	ALLEGHENY
TZAKIS, MD, ANDREAS G	ALLEGHENY
TZARNAS, MD, CHRIS D	PHILADELPHIA

U

UBER, MD, THOMAS R	LAWRENCE
UBERTI, MD, ANTHONY F	WASHINGTON
UBERTI, DO, FREDERICK G	MERCER
UBERTI-BENZ, MD, MARIE O	MONTGOMERY
UDARBE, MD, GUILLERMO G	ELK/CAMERON
UDEKWU, MD, BETTY O	ALLEGHENY
UDELL, MD, LOUIS	PHILADELPHIA
UDIS, MD, DAVID S	PHILADELPHIA
UDOMSAK, MD, PARAMIN	LACKAWANNA
UDOSHI, MD, MALLAPA B	LUZERNE
UFBERG, MD, MICHAEL H	LEHIGH
UGENT, MD, STEVEN J	PHILADELPHIA
UHLAND, MD, HUGO	ALLEGHENY
UHLMAN, MD, ERIC J	CHESTER
UHLMAN, MD, RICHARD C	CHESTER
UHRICH, MD, KATHRYN H	LEBANON
UKNIS, MD, AUDREY B	PHILADELPHIA
UKNIS, MD, MARC E	ALLEGHENY
ULASEWICZ, MD, CATHERINE C	BUCKS
ULASEWICZ, MD, JOSEPH T	MONTGOMERY
ULBRECHT, MD, JAN S	CENTRE
ULICHNEY, ANDREW S	STUDENT
ULICNY, MD, THOMAS L	ALLEGHENY
ULIZIO, MD, ANTHONY R	ALLEGHENY
ULRICH, MD, JACK M	ALLEGHENY
ULRICH, MD, SAMUEL D	DAUPHIN
ULTMANN, MD, MICHELLE C	ALLEGHENY
ULUS, MD, AHMET	PHILADELPHIA
UMALI, MD, IDONA C	LUZERNE
UMALI JR, MD, MELECIO J	BUCKS
UMAR, MD, KENAN	MONTGOMERY
UMEH, MD, ONUORAH I	PHILADELPHIA
UMLAUF, MD, CHARLES W	LEHIGH
UNAL, MD, ABDURRAHMAN	DAUPHIN
UNDERBERG-DAVIS, MD, SHARON J	PHILADELPHIA
UNDERHILL, MD, WILLIAM L	ERIE
UNDERWOOD, MD, MARA Z	MONTGOMERY
UNDERWOOD, MD, SUSAN K	MONTGOMERY
UNGAR-SARGON, MD, JULIAN Y	DELAWARE
UNGER, MD, ANDREW	NORTHAMPTON
UNGER, DANA R	STUDENT
UNGER, MD, MICHAEL	MONTGOMERY
UNIACKE, MD, BRIAN M	DAUPHIN
UNWIN, MD, WILLIAM M	YORK
UPDEGRAFF, MD, WILLIAM C	ALLEGHENY
UPDEGROVE, MD, JOHN H	NORTHAMPTON
UPDEGROVE, MD, ROBERT A	LYCOMING
UPDIKE JR, MD, FURMAN T	YORK
URAM, MD, HERBERT	ALLEGHENY
URASH, DO, JOSEPH J	LUZERNE
URBACH, MD, FREDERICK	MONTGOMERY
URBACH, MD, JOHN R	PHILADELPHIA
URBAN, MD, CLIFFORD H	CHESTER
URBAN, MD, DONALD G	CUMBERLAND
URBAN, MELANIE A	STUDENT
URBAN, NANCY D	STUDENT
URBAN, MD, RENA L	ALLEGHENY
URBAN, MD, RICHARD S	ALLEGHENY
URBAN, MD, ROBERT R	WESTMORELAND
URBANO, MD, ANTHONY M	NORTHAMPTON
URBANSKI, LINDA M	STUDENT
URBANSKI, MD, TIMOTHY E	MONTGOMERY
URDA, MD, DEBORAH L	PHILADELPHIA
URI, MD, ANTONIA K	PHILADELPHIA
URIBE, MD, ALEXANDER	DELAWARE
URICCHIO, MD, FRANCIS J	PHILADELPHIA
URICCHIO, MD, JOSEPH F	PHILADELPHIA
UROSKIE, MD, THEODORE W	LACKAWANNA
UROSKIE JR, THEODORE W	STUDENT
URQUHART, MD, MARION LENA	PHILADELPHIA
URREA, MD, OSCAR	WASHINGTON
USHINSKI, MD, STANLEY C	LUZERNE
USTYNOSKI, MD, KENNETH R	LUZERNE
UTBERG, MD, JOHN R	ALLEGHENY
UTSINGER, MD, PETER D	MONTGOMERY
UTZ, JEFFREY P	STUDENT
UY, MD, HENRY T	WASHINGTON
UY, MD, NONITA T	ALLEGHENY

V

VACCARO, MD, V MICHAEL	PHILADELPHIA
VACCARO III, MD, ALEXANDER R	PHILADELPHIA
VACHARAT, MD, NIBONDH	PHILADELPHIA
VACHHANI, MD, MANSUKHLAL P	NORTHAMPTON
VACHRANUKUNKIET, MD, THEERASAKID	MONTGOMERY
VAFEAS, MD, JOYCE A	LANCASTER
VAGANOS, MD, STEVE A	MONTGOMERY
VAGLEY, MD, RICHARD T	ALLEGHENY
VAHEDI, MD, HOUSHANG M	MONTGOMERY
VAIAS, LYDIA J	STUDENT
VAIDYA, MD, SHAILENDRA	PHILADELPHIA
VAIL, MD, SYDNEY J	MONTGOMERY
VAKHARIA, MD, BHARAT M	MCKEAN
VAKHARIA, MD, PRATIBHA V	MIFFLIN/JUNI
VAKHARIA, MD, VIJAY H	MIFFLIN/JUNI
VAKIL, MD, HASSAN C	DELAWARE
VALCARCEL, MD, SOFRONIO J	ALLEGHENY
VALDERRAMA, MD, HUGO T	LUZERNE
VALDES, MD, CONRADO A	MCKEAN
VALDIVIA, MD, DUILIO E	MIFFLIN/JUNI
VALENA, MD, ELENA V	MERCER
VALENCIA, MD, CELEDONIO C	BERKS
VALENTA, MD, GEORGE F	LUZERNE
VALENTEEN, MD, J WALTER	DELAWARE
VALENTI, MICHAEL A	STUDENT
VALENTINE, MD, JEROME D	PHILADELPHIA
VALENTINO, DO, STEVEN J	MONTGOMERY
VALERIANO, MD, JAMES P	ALLEGHENY
VALIGORSKY, MD, PAUL J	ELK/CAMERON
VALKO, MD, ANNEMARIE S	ALLEGHENY
VALKO, MD, GEORGE P	PHILADELPHIA
VALLABH, MD, SAGAR V	MERCER
VALLE, MD, EDGAR O	DELAWARE
VALLEJO, MD, MANUEL C	WASHINGTON
VALLIAPPAN, MD, SWAMINATHAN	ALLEGHENY
VALLOROSI, CHRISTOPHER J	STUDENT
VALLOW, MD, MORTON J	PHILADELPHIA
VALVERDE, MD, MARIO F	LACKAWANNA
VAN ARSDALE, CINDY M	STUDENT
VAN BLARGAN, DO, MARK S	CHESTER
VAN DE BEEK, MD, M LOUIS	PHILADELPHIA
VAN DECKER, MD, WILLIAM A	PHILADELPHIA
VAN GUNDY, MD, THERESA A	ALLEGHENY
VAN HOVE, MD, SHAWN P	ERIE
VAN NEWKIRK, LAURA E	STUDENT
VAN STAVERN, GREGORY P	STUDENT
VAN TIL, ETHAN S	STUDENT
VAN VOORHEES, MD, ABBY S	MONTGOMERY
VANANTWERP, MD, KENNETH J	SOMERSET
VANBUSKIRK, MD, CHARLES	YORK
VANDAMIA, MD, DONALD N	ERIE
VANDENBELT, ANNE K	STUDENT
VANDER, MD, JAMES F	PHILADELPHIA
VANDERBEEK, MD, RICHARD R	BUCKS
VANDERLIN, MD, ROBERT L	LYCOMING
VANDERPOOL, MD, RAMON A	BUCKS
VANDERVEER, MD, JOSEPH B	MONTGOMERY
VANDERVEER, MD, LINDSLEY D	NORTHAMPTON
VANDUUREN, MD, ANTON	FRANKLIN
VANDYK, MD, KLAAS	WESTMORELAND
VANETT, MD, BRUCE S	DELAWARE
VANGAALEN, MD, ADRIAAN J	NORTHAMPTON
VANGIESEN, MD, PETER J	YORK
VANGORE, MD, SURYA K	PHILADELPHIA
VANHOUTEN, MD, ROBERT J	ADAMS
VANKIRK JR, MD, JOHN S	ALLEGHENY
VANMETER, RICHARD A	STUDENT
VANNATTA, MD, FRED C	WAYNE/PIKE
VANPUTTE, MD, LAURA J	ALLEGHENY
VANRIPER, MD, DANIEL F	PHILADELPHIA
VANSANT, MD, ALAN E	YORK
VANSCOTT, MD, EUGENE J	MONTGOMERY
VANSTRIEN, MD, ADRIAN R	WASHINGTON
VANVORIS, MD, LEE P	ERIE
VANWYK, MD, RITA E	YORK
VARACALLO, MD, ALBERT L	JEFFERSON
VARADA, MD, ANNAPOORNA	PHILADELPHIA
VARADA, MD, K P BABU	MONTGOMERY
VARANO, MD, LOTTIE A	LANCASTER
VARANO, MD, VINCENT J	MONTOUR
VARDARO, MD, LINA G	PHILADELPHIA
VARE JR, MD, VICTOR B	MONTGOMERY
VARGA, MD, JEFFREY M	ALLEGHENY
VARGA, MD, JULIE L	PHILADELPHIA
VARINDANI, MD, MAHESH	ALLEGHENY
VARKER, MD, CAROLYN B	PHILADELPHIA
VARLEY, MD, WILLIAM A	ALLEGHENY
VARLEY, MD, WILLIAM J	ALLEGHENY
VARLOTTA, MD, LAURIE	PHILADELPHIA
VARMA, MD, NEENA	DAUPHIN
VARMA, MD, RAJIV R	ALLEGHENY
VARON, MD, STUART R	ALLEGHENY
VASILE, MD, JOSEPH S	ALLEGHENY
VASILY, MD, DAVID B	NORTHAMPTON
VASQUEZ, MD, JAVIER A	CUMBERLAND
VASSALLO, DO, FRANK A	PHILADELPHIA
VASSALLO, MD, RICHARD W	PHILADELPHIA
VASSALLO JR, MD, RALPH R	MONTGOMERY
VASSALLUZZO, MD, JULIO E	BUCKS
VASSALLUZZO, DO, PETER D	PHILADELPHIA
VASTA, MD, ALFRED G	BUCKS
VASTINE, MD, JOHN R	NORTHMBRLAND
VASUDEVAN, MD, GOPALAN	WESTMORELAND
VASUDEVAN, MD, RAGHAVAN	LYCOMING
VATES, MD, CHARLES W	ALLEGHENY
VAUGHN JR, MD, ARTHUR R	PHILADELPHIA
VAYONIS, MD, ANDREW G	ALLEGHENY
VAZALES, MD, BRAD E	LANCASTER
VAZQUEZ, MD, JORGE	WASHINGTON
VAZQUEZ, MD, ROGER L	ALLEGHENY
VAZQUEZ-ARAN, MD, ANNETTE	MONROE
VEACH, MD, STEPHEN R	MONTGOMERY
VEALE, MD, KRISTEN A	DELAWARE
VEET, LAURE L	STUDENT
VEGA, MD, ROGELIO E	ARMSTRONG
VEGARI, MD, MATT M	MONROE
VEGLIA, MD, ANTHONY P	SCHUYLKILL
VEGLIA, MD, KATHLEEN S	LUZERNE
VEKARIA, MD, KISHOR-KUMAR S	LACKAWANNA

VELAS, MD, CARLOS M NORTHAMPTON
VELAYO, MD, DANTE P UNION
VELEZ, MD, RAFAEL I WESTMORELAND
VELEZ-RIVERA, MD, CARLOS A PHILADELPHIA
VEMULAPALLI, MD, KUTUMBARAO ERIE
VEMULAPALLI, MD, LAKSHMI R ERIE
VENA, VINCENT STUDENT
VENABLE JR, MD, JOHN E ERIE
VENGROVE, DO, MARC A NORTHAMPTON
VENIER, MD, LEON H BERKS
VENIT, MD, BETHANY A LUZERNE
VENTRE, MD, SUSAN LACKAWANNA
VENTURA, MD, CECILIA R LACKAWANNA
VENTURA, MD, SAMUEL R LACKAWANNA
VERDESCA, MD, STEPHEN A PHILADELPHIA
VERDI, MD, CAROL A PHILADELPHIA
VERGARA, MD, J ROBERTO WAYNE/PIKE
VERGARE, MD, MICHAEL J PHILADELPHIA
VERGIS, MD, EMANUEL N ALLEGHENY
VERGIS, MD, JAMES G BUCKS
VERMA, MD, MAHESHWER B NORTHAMPTON
VERMA, MD, RAKESH C PHILADELPHIA
VERMA, MD, SANJEEV K PHILADELPHIA
VERMEIRE, MD, DAVID A MERCER
VERNICK, MD, CLIFFORD G LEHIGH
VERNICK, MD, JEROME J PHILADELPHIA
VERNINO, DO, RICHARD JAMES ALLEGHENY
VERNINO, MD, ROCCO A ALLEGHENY
VERNOCY, MD, WILLIAM C INDIANA
VERNON JR, MD, THOMAS M PHILADELPHIA
VERONESI, DO, JOHN N JEFFERSON
VERSAGE, MD, JOSEPH L NORTHAMPTON
VERTOSICK JR, MD, FRANK T ALLEGHENY
VERY, MD, RONALD M ALLEGHENY
VERZELLA, MD, JEFFREY N LYCOMING
VESIO, MD, KENNETH D ALLEGHENY
VEY, MD, EDWIN K ALLEGHENY
VEY, MD, ERIC L ALLEGHENY
VICKERS, MD, CURTIS W COLUMBIA
VICKERS, MD, JEAN L ERIE
VICKERY, MD, JON L DAUPHIN
VICTOR, MD, MARK F PHILADELPHIA
VIECHNICKI, MD, M BRUCE LEHIGH
VIERA, MD, ANGEL ALLEGHENY
VIGDAROVICH, MD, VLADIMIR NORTHUMBERLAND
VIGILANTE, MD, MICHAEL LEHIGH
VIGLIONE, MD, JOSEPH P MONROE
VIJAYAMOHAN, MD, GOVINDARAJULU INDIANA
VIJAYKUMAR, MD, PUVALAI M ALLEGHENY
VILLA, MD, FRANCISCO B POTTER
VILLACRUSIS, MD, OSCAR C LUZERNE
VILLAGRA, MD, VICTOR G MONTOUR
VILLARE, MD, ANTHONY W PHILADELPHIA
VILLARREAL, MD, CARLOS X SCHUYLKILL
VILLARS, MD, FREDERICK BERKS
VILLASIN, MD, JOSEPH V LACKAWANNA
VILLAVICENCIO-NOCHE, MD, LYDIA L FAYETTE
VILLEGAS, MD, ANTONIO C MONTGOMERY
VILLEGAS, MD, EMILIO WESTMORELAND
VILLELLA, MD, EDWARD R ALLEGHENY
VILOGI, MD, JOSEPH P LACKAWANNA
VILUSHIS, DO, GEORGE J ERIE
VIN, MD, PRAKASH K WESTMORELAND
VINCENS, MD, JAMES J PHILADELPHIA
VINCENT, MD, GREGORY J BUCKS
VINCENT, MD, JOSEPH E LEHIGH
VIOLA, MD, ANNETTE M CHESTER
VIOLAGO, MD, EDUARDO S DAUPHIN
VIRELLA, WILMA STUDENT
VIRGILE, MD, ROGER S H VENANGO
VISCUSI, MD, DONALD J ERIE
VISHNEVSKY, MD, MARINA MONTGOMERY
VISNESKI, DO, PAUL E LANCASTER
VISOT, MD, LUIS R SCHUYLKILL
VISPERAS, MD, EMILIANA P NORTHAMPTON
VISPERAS, MD, MARIO F CARBON
VISWANATHAN, MD, BYRAVAN ADAMS
VITALE, MD, LOUIS J LACKAWANNA
VITANZA, DO, SEBASTIAN A ERIE
VITTONE, MD, DANIEL C WESTMORELAND
VITTONE, MICHAEL A STUDENT
VITTONE, MD, RONALD B WESTMORELAND
VITTONE, ROSEMARY STUDENT
VIVIAN, MD, GAIL M CHESTER
VIVINO, MD, FREDERICK B PHILADELPHIA
VIZER, MD, MARK B BUCKS
VLAHOS, DO, PATRICK J ALLEGHENY
VLESSING, MD, EVA BUCKS
VNENCHEK, MD, PAMELA A LANCASTER
VOCI, MD, GERARDO PHILADELPHIA
VOGAN, MD, CLIFFORD R ARMSTRONG
VOGAN, MD, WILLIAM R MERCER
VOGEL, ERIC W STUDENT
VOGEL JR, MD, JULIUS A BEAVER
VOGELEY, MD, EVA A ALLEGHENY
VOGIN, MD, EUGENE E PHILADELPHIA
VOGLER JR, MD, WILFRED E NORTHAMPTON
VOGT, MD, MERLE A DELAWARE
VOGUS, MD, JAMES B WARREN
VOJVODA, MD, DOLORES PHILADELPHIA
VOLIN, MD, JAN J MONTGOMERY
VOLK, MD, FRANCIS N PHILADELPHIA
VOLK, MD, STEPHEN A NORTHAMPTON
VOLKAR, MD, JUDITH K CAMBRIA
VOLKIN, MD, LEONARD B ALLEGHENY
VOLKIN, MD, ROBERT L ALLEGHENY
VOLLMAR II, MD, WILLIAM R LANCASTER
VOLLMER, MD, TIMOTHY P MONTOUR
VOLOSKY, MD, ROBERT L ALLEGHENY
VOLPE, DO, JOHN J BUCKS
VOLPP, KEVIN G M STUDENT
VON SOHSTEN, MD, ROBERTO L PHILADELPHIA
VONDERPORTEN, MD, KENNETH P ALLEGHENY
VOONG, CALVON A STUDENT
VOORA, MD, SAMBASIVARAO ERIE
VORA, MD, PRAFULLCHANDRA GREENE
VORA, SUJAY A STUDENT
VORASINGHA, MD, THONGCHAI PHILADELPHIA
VORE, MD, KIMBERLE K WASHINGTON
VORE, MD, STEVEN B CENTRE
VOSK, MD, ARNO D LYCOMING
VOSSENBERG, MD, FRANS J MONTGOMERY
VOUTSINAS, MD, LOUISA V LUZERNE
VOYCE, MD, STEPHEN J LACKAWANNA
VOYTKO, MD, RICHARD E CAMBRIA
VRABEC, MD, DONALD P MONTOUR
VREELAND, MD, JAMES H BEDFORD
VROOMAN, MD, SAMUEL C PHILADELPHIA
VU, KHANH H STUDENT
VUJAN, MD, ALEXANDER S ALLEGHENY
VUJEVICH, MD, MARION M ALLEGHENY
VUKMER, MD, GEORGE J VENANGO
VUKMER JR, MD, GEORGE J CRAWFORD
VUOLO, MD, MARK D MONTGOMERY
VYAS, MD, RAJIV K ALLEGHENY
VYDAS, MD, SAULIUS J CENTRE
VYTLACIL, MD, MARK R CAMBRIA

W

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WADDINGTON, MD, ARTHUR W PHILADELPHIA
WADE, MD, FRANKLIN G LYCOMING
WADE, MD, GEORGE R CHESTER
WADE, MD, JEANNE A ERIE
WADE, MD, ROBERT B MONTOUR
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WADHWA, MD, KAMAL P LAWRENCE
WADHWA, MANISH K STUDENT
WADHWA, MD, RAJINDAR K ALLEGHENY
WADHWA, MD, BAROJ R ALLEGHENY
WADHWANI, MD, BHAGWAN J WASHINGTON
WAGENFUHR, MD, TIMM CHESTER
WAGENHEIM, MD, HARRY H PHILADELPHIA
WAGENHEIM, MD, HELEN S PHILADELPHIA
WAGGENSPACK, MD, GERARD A YORK
WAGMAN, MD, ALBERT D PHILADELPHIA
WAGMAN, MD, PHILIP G LAWRENCE
WAGNER, MD, BARBARA C MONROE
WAGNER, MD, CHARLES I MONTGOMERY
WAGNER, MD, DAVID K PHILADELPHIA
WAGNER, MD, J KENT L LEBANON
WAGNER, MD, JERE L NORTHUMBERLAND
WAGNER, MD, JOHN B BERKS
WAGNER, MD, JOHN M LACKAWANNA
WAGNER, MD, JOSEPH A PHILADELPHIA
WAGNER, MD, KRISTINA M DAUPHIN
WAGNER, MD, LOUIS J BLAIR
WAGNER, MD, ROBERT A VENANGO
WAGNER, MD, ROBERT E POTTER
WAGNER, MD, W JOHN LYCOMING
WAGNER JR, MD, FREDERICK B PHILADELPHIA
WAGNER JR, MD, RICHARD S LANCASTER
WAHBA, MD, HANEY N WESTMORELAND
WAHHAB, MD, ABDUL SCHUYLKILL
WAHRENBERGER, MD, JACK T ALLEGHENY
WAIBEL, MD, DAVID A LACKAWANNA
WAIBEL, MD, JOHN T BLAIR
WALBERG, MD, HARRY W ALLEGHENY
WALD, MD, LAWRENCE M PHILADELPHIA
WALD, MD, NIEL ALLEGHENY
WALDEN, MD, THOMAS B NORTHAMPTON
WALDHAUSEN, MD, JOHN A DAUPHIN
WALDMAN, MD, CLIFFORD R ALLEGHENY
WALDMAN, MD, JOSEPH PHILADELPHIA
WALDMAN, SARAH E STUDENT
WALDMAN, MD, SCOTT A PHILADELPHIA
WALDMAN, MD, TERRY L PHILADELPHIA
WALDNER, JOSEPH F STUDENT
WALDO, MD, RALPH F INDIANA
WALDOR, MD, PHILIP A CHESTER
WALDROP, MD, CHARLES D MONTOUR
WALHEIM, MD, JON P BUCKS
WALICHUCK, MD, JOHN G DELAWARE
WALIGURA, DO, R CURTIS ALLEGHENY
WALINSKY, MD, PAUL PHILADELPHIA
WALKER, MD, ANDREW S LEHIGH
WALKER, ANNE M STUDENT
WALKER, MD, BARRY R PHILADELPHIA
WALKER, MD, BRIAN K CENTRE
WALKER, BRUCE J STUDENT
WALKER, GREGORY E STUDENT
WALKER, MD, HERBERT I PHILADELPHIA
WALKER, MD, JAMES F ERIE
WALKER, MD, JOHN S MONTGOMERY
WALKER, MD, JON G LANCASTER
WALKER, MD, KIMBERLY C PHILADELPHIA
WALKER, MD, LEVI ALLEGHENY
WALKER, MD, M LORENZO PHILADELPHIA
WALKER, MD, MARCELLUS A WAYNE/PIKE
WALKER, MD, MARGARET E PHILADELPHIA
WALKER, MD, MARY A ALLEGHENY
WALKER, MATTHEW T STUDENT
WALKER, MD, ROBERT L MONTOUR
WALKER, MD, STEPHEN R DELAWARE
WALKER, MD, TERRI M DAUPHIN
WALKER, MD, WILLIAM R LANCASTER
WALKER JR, MD, LEROY L PHILADELPHIA
WALKOWSKI JR, MD, EDWARD J LACKAWANNA
WALL, MD, JAMES R LEHIGH
WALL, MD, JOHN N ALLEGHENY
WALL, MD, NORMAN M SCHUYLKILL
WALL, MD, ROD A CAMBRIA
WALLACE, MD, HOMER D ALLEGHENY
WALLACE, MD, IRA B PHILADELPHIA
WALLACE, MD, KATHLEEN A ALLEGHENY
WALLACE, MD, RICHARD P PHILADELPHIA
WALLACE, MD, THOMAS E LYCOMING
WALLACE, MD, WILBUR S ERIE
WALLACE JR, MD, JOSEPH DELAWARE
WALLACH, MD, LAWRENCE DELAWARE
WALLEN, MD, ROBERT C MONROE
WALLER, MD, JOAN C DELAWARE
WALLER, MD, LOUIS C LACKAWANNA
WALLER, MD, LOUIS C ALLEGHENY
WALLERSTEIN, MD, EDWARD M ERIE
WALLEY III, MD, ROBERT E ALLEGHENY
WALLIA, MD, RAJNI ALLEGHENY
WALLICK, MD, PETER G FRANKLIN
WALLIN, MD, BRUCE A PHILADELPHIA
WALLIN, MD, THOMAS E DAUPHIN
WALLISCH, MD, MICHAEL D POTTER
WALLNER, DO, PAUL E PHILADELPHIA
WALLOWER, DO, LORI L FRANKLIN
WALLS, DO, THERESA A LANCASTER
WALLS, ADMIN SEC, BARBARA BUTLER
WALMER, MD, JOHN D LEBANON
WALNISTA, MD, FRANK J LACKAWANNA
WALOFF, MD, RONALD I PHILADELPHIA
WALOR, OFF MANAGER, MARGARET M WESTMORELAND
WALRATH III, MD, MARTIN H ALLEGHENY
WALSH, MD, ARTHUR C ALLEGHENY
WALSH, MD, DEIRDRE V MONTGOMERY
WALSH, MD, DOUGLAS M DAUPHIN
WALSH, MD, JAMES C LUZERNE
WALSH, MD, JOHN J ALLEGHENY
WALSH, DO, JOHN R DELAWARE
WALTER, MD, BARBARA J CHESTER
WALTER, MD, C LEE ALLEGHENY
WALTER, MD, DANIEL S PHILADELPHIA
WALTER, MD, DAVID L VENANGO
WALTER, MD, RICHARD D LYCOMING
WALTER, MD, WILLIAM J ALLEGHENY
WALTERS, MD, CLOVA E NORTHAMPTON
WALTERS, DO, DONALD A ALLEGHENY
WALTERS, MD, WILLIAM H SCHUYLKILL
WALTERS, MD, WILLIAM S WARREN
WALTHER, MD, BRENDA L ALLEGHENY
WALTMAN, MD, CHARLES A NORTHAMPTON
WALTZ, MD, JOHN S ALLEGHENY
WALTZ, MICHAEL D STUDENT
WALTZ, MD, PAUL K DAUPHIN
WALTZER, MD, FREDERICK N MONTGOMERY
WAMPLER, MD, DAVID L CUMBERLAND
WAMPLER, MD, M JOHN YORK
WANAMAKER, MD, JOHN L BRADFORD
WANCZYK, MD, CASIMIR J BERKS
WANG, MD, BARBARA K WESTMORELAND
WANG, MD, CHEE K NORTHAMPTON
WANG, MD, GEORGE C DELAWARE
WANG, JOHN Y STUDENT
WANG, MD, SHEN-CHI MERCER
WANG, MD, THOMAS N PHILADELPHIA
WANG, MD, YAO C LACKAWANNA
WAPENSKI, MD, JOSEPH A ALLEGHENY
WAPNER, MD, JOHN M LEHIGH
WAPNER, MD, KEITH L PHILADELPHIA
WAPNER, MD, PAUL M PHILADELPHIA
WARAVDEKAR, MD, NEIL V PHILADELPHIA
WARD, MD, EDGAR H ERIE
WARD, MD, EDWARD J DELAWARE
WARD, MD, H RICHARD UNION
WARD, MD, MARY J COLUMBIA
WARD, MD, MICHAEL J A CHESTER
WARD, MD, SAMUEL P DAUPHIN
WARD, MD, STEPHEN D MONTGOMERY
WARD, MD, TIMOTHY J ERIE
WARD, MD, W TIMOTHY ALLEGHENY
WARD JR, MD, MAURICE J CHESTER
WARD JR, MD, THOMAS D WESTMORELAND
WARDE, MD, DONAL A ALLEGHENY
WARDEN, MD, JAMES R ERIE
WARE, MD, PAUL D PHILADELPHIA
WARE, MD, WILLIAM B BEAVER
WARE, MD, WILLIAM C DELAWARE
WARFIELD, MD, ANNA S DELAWARE
WARGO, MD, PETER J ALLEGHENY
WARHOL, MD, MICHAEL J PHILADELPHIA
WARIKOO, MD, SHIBAN K CAMBRIA
WARK, MD, JAMES E PHILADELPHIA
WARNER, MD, HOWARD F PHILADELPHIA
WARNER, DO, MARIE J MONTOUR
WARNER, MD, NORMAN M CHESTER
WARNER, MD, ROBERT E ALLEGHENY
WARNER, MD, ROBERT H ALLEGHENY
WARNER JR, MD, RONALD L STUDENT
WARNICK, MD, RICHARD D PHILADELPHIA
WARREN, DAVID K STUDENT
WARREN, MD, JAMES W DAUPHIN
WARREN, MD, JONATHAN NORTHAMPTON
WARREN, MD, KENNETH C MONTGOMERY
WARREN, MD, WILLIAM L CHESTER
WARRENDER, MD, WILLIAM F BUCKS
WARTELLA JR, MD, STEPHEN LUZERNE
WASHBURN, MD, VIRGINIA E ALLEGHENY
WASHBURNE MOYLAN, MD, JAQUELINE D PHILADELPHIA
WASHINGTON, MD, BUFORD S PHILADELPHIA
WASHOFSKY, RICHARD A STUDENT
WASIEWSKI, MD, WARREN W LANCASTER
WASILEWSKI JR, MD, CHARLES L LYCOMING
WASKO, MD, MARGERY L DAUPHIN
WASKO, MD, ROBERT LEHIGH
WASNICK, MD, WILLIAM LUZERNE
WASSERMAN, MD, ANDREW P PHILADELPHIA
WASSERMAN, CHANA S STUDENT
WASSERMAN, MD, HENRY LEBANON
WASSERMAN, MD, KENNETH E PHILADELPHIA
WASSIL, JOHN G STUDENT
WASSIL, MD, JOHN G MERCER
WASSIL JR, MD, JOHN G MERCER
WATERS, MD, MARK H ALLEGHENY
WATERS, MD, MICHAEL N ALLEGHENY
WATERS, DO, PATRICK T PHILADELPHIA
WATKIN JR, MD, WALTER B DAUPHIN
WATKINS, MD, GEORGE M NORTHAMPTON
WATKINS, MD, GLORIA J WESTMORELAND
WATSON, MD, CHARLES G ALLEGHENY
WATSON, MD, JAMES G MONTGOMERY
WATSON, MD, JAMES R ALLEGHENY
WATSON, MD, MARIA J PHILADELPHIA
WATSON, MD, WILLIAM GRAY ALLEGHENY
WATSON III, MD, ROBERT A PHILADELPHIA
WATSON-GRAY, KATHIE L STUDENT
WATTERS, MD, EDMOND C ALLEGHENY
WATTERSON, MD, SAMUEL G SOMERSET
WAWRO, MD, PETER A PHILADELPHIA
WAWROSE, MD, FREDERICK E HUNTINGDON
WAY, MD, GEORGE E CAMBRIA
WAYLONIS, MD, J ROBERT ALLEGHENY
WEADER, MD, JOSEPH A MONTOUR
WEADER, MD, WILLIAM M NORTHUMBERLAND
WEAN, MD, LAWRENCE P DELAWARE
WEANER, DO, SCOTT M PHILADELPHIA
WEASON, MD, STEVEN R BUCKS
WEATHERBY III, MD, ELLSWORTH BUCKS
WEAVER, MD, AARON R LANCASTER
WEAVER, MD, AMY LU CENTRE
WEAVER, MD, DON K LYCOMING
WEAVER, MD, FRANK M YORK
WEAVER, DO, GLENN E LUZERNE
WEAVER, MD, JAMES D ERIE
WEAVER, MD, JEAN M CAMBRIA
WEAVER, MD, KENT E BERKS
WEAVER, MD, LUNDA E BLAIR
WEAVER, MD, M FAY BERKS
WEAVER, MD, MILES L ALLEGHENY
WEAVER, DO, RICHARD A MONTGOMERY
WEAVER, DO, RICHMAN G YORK
WEAVER, MD, ROBERT P CENTRE
WEBB, MD, ELIZABETH S MONTGOMERY
WEBB III, MD, PAUL R BRADFORD
WEBBER, MD, CAROL P MONTGOMERY
WEBBER, MD, JOHN B PHILADELPHIA
WEBER, ALLAN A STUDENT
WEBER, MD, DANIEL I DAUPHIN
WEBER, MD, DAVID R ALLEGHENY
WEBER, ERIC A STUDENT
WEBER, MD, GEORGE L DELAWARE
WEBER, JEFFREY K STUDENT
WEBER, MD, JOHN E ALLEGHENY
WEBER, MD, JOHN I PHILADELPHIA
WEBER, MD, LAWRENCE ALLEGHENY
WEBER, MD, MARGARET ELLEN PHILADELPHIA
WEBER, MD, OTTO R MONROE
WEBER, MD, RICHARD H LANCASTER
WEBER, MD, STANLEY ALLEGHENY
WEBER, MD, STEPHEN F LYCOMING
WEBER, MD, STEVEN J BUCKS
WEBER, MD, WILLIAM C NORTHAMPTON
WEBSTER, MD, JOHN H ALLEGHENY
WEBSTER, MD, LANE TIOGA
WEBSTER, MD, MARSHALL W ALLEGHENY
WEBSTER, MICHAEL L STUDENT
WECHSLER, MD, HARRY L ALLEGHENY
WECHSLER, MD, LAWRENCE R ALLEGHENY
WECHSLER, MD, RICHARD L ALLEGHENY
WECHT, MD, CYRIL H ALLEGHENY
WEDEEN, MD, ROBERT S CHESTER
WEDEMEYER, MD, ANNE L ALLEGHENY
WEDEMEYER, MD, PHILLIPS P ALLEGHENY
WEE, MD, ENG C MERCER
WEED, MD, ALLEN S MONTGOMERY
WEED, MD, MICHAEL K LANCASTER
WEHBE, MD, MARWAN A MONTGOMERY
WEHRER, MD, JULIE A ERIE
WEI, MD, LAWRENCE C POTTER
WEI, MD, LAWRENCE M ALLEGHENY
WEIBEL, CHRISTOPHER J STUDENT
WEIBEL, MD, DAVID C UNION
WEIBEL, MD, ROBERT E DELAWARE
WEIBEL, MD, SANDRA B PHILADELPHIA
WEIDA, MD, THOMAS J LANCASTER
WEIDENHAMER, MD, MONICA L ALLEGHENY
WEIDMAN, MD, DAVID A ALLEGHENY
WEIDMAN, EXEC DIR, BRUCE R BERKS
WEIDNER, BRYAN C STUDENT
WEIDNER, MD, JAMES R STUDENT
WEIDNER, MD, PAUL L BUCKS
WEIDNER, MD, SANDRA L BERKS
WEIGEL, MD, A LINN ALLEGHENY
WEIGEL, MD, JESSE A DAUPHIN
WEIGEL, MD, JOSEPH H BEAVER
WEIGEL JR, MD, JOHN E ALLEGHENY
WEIGHTMAN, MD, JOSEPH UNION
WEIGLER, MD, RICHARD R ALLEGHENY
WEIKERS, MD, NORBERT J ALLEGHENY

WEIL, MD, VALERIE P	PHILADELPHIA
WEIMER, MD, GREGORY R	CENTRE
WEIN, MD, ALAN J	PHILADELPHIA
WEIN, MD, THOMAS P	ALLEGHENY
WEINBAUM, MD, DAVID L	ALLEGHENY
WEINBERG, MD, CARROLL A	DELAWARE
WEINBERG, MD, DANIEL J	PHILADELPHIA
WEINBERG, MD, J DAVID	LANCASTER
WEINBERG, JEFFREY M	STUDENT
WEINBERG, MD, JOEL H	ALLEGHENY
WEINBERG, MD, MICHAEL G	WESTMORELAND
WEINBERG, MD, RICHARD A	DELAWARE
WEINBERG, MD, RICHARD L	ALLEGHENY
WEINBERGER, MD, IRVING G	ALLEGHENY
WEINBERGER, MD, MICHAEL W	ALLEGHENY
WEINBLATT, MD, HOWARD A	PHILADELPHIA
WEINER, MD, BRUCE	MONTGOMERY
WEINER, MD, FRANK	INDIANA
WEINER, MD, GERALD H	LAWRENCE
WEINER, MD, HAROLD M	MONTGOMERY
WEINER, MD, HERMAN L	PHILADELPHIA
WEINER, DO, IRA H	DELAWARE
WEINER, MD, JACK	PHILADELPHIA
WEINER, MD, JEFFERY R	MONTGOMERY
WEINER, MD, LEON J	PHILADELPHIA
WEINER, MD, MARC H	LANCASTER
WEINER, MD, ROBERT A	MERCER
WEINGARTEN, MD, MARTIN Z	PHILADELPHIA
WEINGARTEN, MD, MICHAEL S	PHILADELPHIA
WEINGOLD, MD, DAVID H	LANCASTER
WEINRIEB, MD, ROBERT M	PHILADELPHIA
WEINSCHENK, MD, NANCY P	PHILADELPHIA
WEINSTEIN, MD, BARBARA J	ALLEGHENY
WEINSTEIN, MD, DAVID P	WESTMORELAND
WEINSTEIN, MD, GARY S	ALLEGHENY
WEINSTEIN, MD, GERALD S	ALLEGHENY
WEINSTEIN, MD, LEE	DAUPHIN
WEINSTEIN, LISA F	STUDENT
WEINSTEIN, MD, MARYANN B	WASHINGTON
WEINSTEIN, MD, ROBERT S	PHILADELPHIA
WEINSTEIN, MD, SAUL F	PHILADELPHIA
WEINSTOCK, MD, JEROME L	MONTGOMERY
WEINSTOCK, MD, ROBERT M	PHILADELPHIA
WEINTRAUB, MD, HARVEY	LUZERNE
WEINTRAUB, MD, RUSSELL	MCKEAN
WEIS, DO, JOHN H	BRADFORD
WEIS, MD, PAUL R	LEHIGH
WEISBERG, MD, EDWARD S	ALLEGHENY
WEISBERG, MD, JEROME S	BERKS
WEISBERG, MD, PAUL S	PHILADELPHIA
WEISBERG, MD, ROBERT A	BUCKS
WEISEL, MD, WILLIAM M	WESTMORELAND
WEISENFLUH, MD, MARK G	ERIE
WEISER, MD, MADELEINE C	MONTGOMERY
WEISER, MD, PAUL J	BUCKS
WEISKOPF, MD, JAY R	ALLEGHENY
WEISMAN, EVAN B	STUDENT
WEISMAN, MD, HARLAN F	CHESTER
WEISMAN, MD, RICHARD A	ALLEGHENY
WEISMER, MD, RICHARD M	LANCASTER
WEISNER, MD, MICHAEL J	UNION
WEISS, MD, ALAN R	MONTGOMERY
WEISS, MD, ALBERT A	PHILADELPHIA
WEISS, MD, BURTON	PHILADELPHIA
WEISS, MD, CARL B	MONROE
WEISS, MD, CHARLES	PHILADELPHIA
WEISS, MD, DAVID L	PHILADELPHIA
WEISS, DO, DEBRA R	PHILADELPHIA
WEISS, MD, EDWARD D	PHILADELPHIA
WEISS, MD, ELISSA	ALLEGHENY
WEISS, MD, ERIC G	PHILADELPHIA
WEISS, MD, FRED H	MONTGOMERY
WEISS, MD, GEORGE H	MONTGOMERY
WEISS, MD, JAMES	ALLEGHENY
WEISS, MD, JEFFREY P	LACKAWANNA
WEISS, MD, JORDAN B	PHILADELPHIA
WEISS, DO, KENNETH S	MONTGOMERY
WEISS, MD, LAURENCE B	PHILADELPHIA
WEISS, DO, MALCOLM D	YORK
WEISS, MD, MALCOLM S	ALLEGHENY
WEISS, MD, MICHAEL W	ALLEGHENY
WEISS, MD, NED M	MONTGOMERY
WEISS, MD, RICHARD D	DELAWARE
WEISS, MD, ROBERT	PHILADELPHIA
WEISS, MD, ROBERT D	ALLEGHENY
WEISS, MD, ROBERT F	ALLEGHENY
WEISS, MD, ROBERT J	WARREN
WEISS, DO, ROBERT J	LEHIGH
WEISS, MD, ROBERTA A	MONTGOMERY
WEISS, DO, ROGER T	FRANKLIN
WEISS, MD, SIDNEY	PHILADELPHIA
WEISS, MD, STEPHEN M	PHILADELPHIA
WEISS, MD, STEVEN J	PHILADELPHIA
WEISS, MD, WILLIAM	PHILADELPHIA
WEISS, MD, WILLIAM B	LUZERNE
WEISS JR, MD, CARL B	NORTHAMPTON
WEISSER, MD, C WILLIAM	ALLEGHENY
WEISSGOLD, MD, DAVID J	PHILADELPHIA
WEISSMAN, MD, JOEL M	PHILADELPHIA
WEISSMAN, MD, MARCUS I	PHILADELPHIA
WEITEKAMP, MD, MICHAEL R	DAUPHIN
WEITZEL, MD, WILLIAM K	ALLEGHENY
WELBY, MD, TIMOTHY D	MONTOUR
WELCH, MD, J PATRICK	LEBANON
WELCH, MD, MARK J	STUDENT
WELDON, MD, JOHN F	WASHINGTON
WELDON, MD, JOHN P	ALLEGHENY
WELDON, PATRICK O	STUDENT
WELKON, MD, CELESTE J	ALLEGHENY
WELLENBACH, MD, BURTON L	PHILADELPHIA
WELLES, MD, LINDA B	ERIE
WELLES, MD, RICHARD V	ERIE
WELLMAN, MD, RICHARD H	BUTLER
WELLS, MD, E BUIST	ERIE
WELLS, MD, GREGG B	PHILADELPHIA
WELLS JR, MD, JACK C	CAMBRIA
WELSCH, MD, FRANK A	BUCKS
WELSH, MD, JAMES F	BERKS
WELSH, SCOTT R	STUDENT
WELTY, MD, KATHERINE K	CLEARFIELD
WEMPLE, MD, JAN B	NORTHAMPTON
WENDELL JR, MD, JAMES I	MONTGOMERY
WENDER, MD, RICHARD C	PHILADELPHIA
WENDLING, MARK A	STUDENT
WENDLING, MD, WOODROW W	PHILADELPHIA
WENG, MD, SAM S	NORTHAMPTON
WENGER, MD, ALLEN S	DAUPHIN
WENGER, MD, ELIZABETH A	PHILADELPHIA
WENGER, MD, JAY A	BUCKS
WENGER, MD, MARLIN E	LANCASTER
WENGER, MD, NORMAN E	LACKAWANNA
WENGER, MD, SIDNEY U	PHILADELPHIA
WENGERT JR, MD, PAUL A	DAUPHIN
WENGROVITZ, MD, PAUL H	CENTRE
WENIGER, MD, FREDERICK C	ALLEGHENY
WENIGER, MD, FREDERICK L	ALLEGHENY
WENKERT, MD, NAOMI E	ALLEGHENY
WENNER, DO, DAVID R	DAUPHIN
WENNER, MD, ROBERT B	LUZERNE
WENNER JR, DO, EARL J	YORK
WENNERSTEN, MD, JACK R	MONTGOMERY
WENTZ, MD, HENRY S	LANCASTER
WENTZLER, MD, J DONALD	UNION
WERLEY, MD, CHARLES W	NORTHAMPTON
WERLEY, MD, JOHN D	NORTHAMPTON
WERNER, MD, A WILLIAM	ELK/CAMERON
WERNER, MD, ALAN M	ALLEGHENY
WERNER, MD, DAVID B	CENTRE
WERNER, MD, DONALD J	LACKAWANNA
WERNER, MD, ELLIOT B	PHILADELPHIA
WERNER, MD, JOYCE Z	CAMBRIA
WERNER JR, MD, JOSEPH H	BUCKS
WERNING, MD, JOHN W	PHILADELPHIA
WERRIN, MD, MARGUERITE W	CHESTER
WERRIN, MD, RONALD J	CHESTER
WERT, MD, ROY E	BRADFORD
WERTH, MD, VICTORIA P	MONTGOMERY
WERTHAN, MD, MERYLEE E	PHILADELPHIA
WERTHEIMER, MD, JOHN H	PHILADELPHIA
WERTHEIMER, MD, MARC J	DELAWARE
WERTHER, MD, NORMAN M	MONTGOMERY
WERTIME, MD, CLARA G	DAUPHIN
WERTZ, MD, ROBERT R	CAMBRIA
WERTZ II, MD, ROBERT E	LANCASTER
WESCHLER, MD, BARBARA	ALLEGHENY
WESNER, MD, NEIL N	LUZERNE
WESS, MD, MICHAEL M	PHILADELPHIA
WESSEL, MD, ISADORE J	PHILADELPHIA
WESSNER-DUNLAP, DO, SUSAN L	MERCER
WEST, MD, EDWARD	CENTRE
WEST, MD, GARY B	YORK
WEST, MD, JOHN C	MONTOUR
WEST, MD, ROBERT B	MIFFLIN/JUNI
WEST, STEVEN E	STUDENT
WEST, MD, WILLIAM B	HUNTINGDON
WEST JR, MD, CLIFTON F	MONTGOMERY
WEST JR, MD, WILLIAM J	BERKS
WEST SR, MD, WILLIAM J	CUMBERLAND
WESTAWSKI, DANIEL B	STUDENT
WESTBY, MD, G RANDOLPH	DELAWARE
WESTCOTT, MD, CARL J	PHILADELPHIA
WESTCOTT, MD, RICHARD J	BERKS
WESTHEIM, MD, ALAN I	MONROE
WESTON, MD, JOHN M	UNION
WESTON, MD, WAYNE L	LACKAWANNA
WESTPHAL, MD, THOMAS R	LANCASTER
WESTRA, DO, KEVIN C	ALLEGHENY
WETMORE, MD, RALPH F	PHILADELPHIA
WETMORE, MD, STANLEY M	DAUPHIN
WETSCHLER, MD, STANLEY S	ALLEGHENY
WETSTONE, MD, JEFFREY B	LYCOMING
WETTLAUFER, MD, MARILYN R	PHILADELPHIA
WETTON, MD, RITA	ALLEGHENY
WETZEL, MD, F TODD	DAUPHIN
WETZEL, DO, GEHRED D	LANCASTER
WETZEL, MD, MARIE A	BLAIR
WETZEL, MD, ROBERT J	YORK
WEXLER, MD, HARRY	PHILADELPHIA
WEXLIN, MD, DONALD J	MONTGOMERY
WEYMAN, RICHARD L	STUDENT
WEYN, MD, ADRIAN S	DELAWARE
WEYN, MD, DAVID C	PHILADELPHIA
WHALEN, MD, THOMAS J	WASHINGTON
WHAREN, MD, ROBERT E	BLAIR
WHARTON, MD, KEITH H	ALLEGHENY
WHARTON, MD, STANLEY W	ERIE
WHATLEY, MD, NANCY E	BRADFORD
WHEATLY, MD, WILLIAM K	LANCASTER
WHEELER, MD, GLEN N	LEBANON
WHEELER, MD, JENETTE H	MONTGOMERY
WHEELER, MD, JOHN S	LEHIGH
WHEELER, MD, LEIGH D	CENTRE
WHEELING, MD, GEORGE H	CAMBRIA
WHELAN, MD, STEPHEN T	DELAWARE
WHETSTONE, MD, CHARLES L	LANCASTER
WHIGHTSEL, MD, JEFFREY W	BLAIR
WHILDIN, MD, JAMES G	NORTHAMPTON
WHIPPLE, MD, DOROTHY S	PHILADELPHIA
WHISNANT, MD, ROBERT A	LEBANON
WHITAKER, MD, H CRAIG	DELAWARE
WHITAKER, MD, J MICHAEL	BUCKS
WHITAKER, MD, LINTON A	PHILADELPHIA
WHITAKER, MD, PAUL J	NORTHAMPTON
WHITCOMB, MD, CLARENCE A	PHILADELPHIA
WHITCOMB, MD, LUTHER M	CUMBERLAND
WHITCOPF, PETER J	STUDENT
WHITE, MD, ALBERT E	BUCKS
WHITE, MD, CAROL J	GREENE
WHITE, MD, CHERYL JO	MONTGOMERY
WHITE, MD, DANETTE	PHILADELPHIA
WHITE, MD, DARYL E	FRANKLIN
WHITE, MD, DAVID A	WASHINGTON
WHITE, MD, DAVID M	PHILADELPHIA
WHITE, MD, FRANK J	SCHUYLKILL
WHITE, MD, GEORGE S	CENTRE
WHITE, MD, JACK C	CHESTER
WHITE, MD, JAMES W	LANCASTER
WHITE, JOHN E	STUDENT
WHITE, MD, JOSEPH G	CHESTER
WHITE, MD, JULIE M	DELAWARE
WHITE, KAREN L	STUDENT
WHITE, MD, KATHLENE	MONTGOMERY
WHITE, MD, KELLEY J	PHILADELPHIA
WHITE, MD, MICHAEL J	ALLEGHENY
WHITE, MD, RICHARD K	LEHIGH
WHITE, MD, ROBERT A	DELAWARE
WHITE, MD, ROBERT P	NORTHAMPTON
WHITE, MD, SCOTT M	DAUPHIN
WHITE, MD, SEAN P	YORK
WHITE, MD, T MICHAEL	CAMBRIA
WHITE, MD, WAYNE D	DAUPHIN
WHITE, MD, WESLEY R	LACKAWANNA
WHITE, MD, WILLIAM L	ALLEGHENY
WHITE, EXEC SEC, ANNE L	FAYETTE
WHITE III, RICHARD J	STUDENT
WHITE JR, MD, ROBERT H	LANCASTER
WHITEBLOOM, DO, DALE	LANCASTER
WHITEFORD, MD, MARK H	PHILADELPHIA
WHITEHOUSE, JULIE A	STUDENT
WHITELEY, MD, JOHN P	YORK
WHITENACK, MD, STEPHEN H	PHILADELPHIA
WHITENER, MD, CYNTHIA J	DAUPHIN
WHITESIDE, DEBORAH A	STUDENT
WHITESIDE, MD, VIRGINIA E	ALLEGHENY
WHITFORD, MD, THEODORE C	ALLEGHENY
WHITING, MD, DONALD M	ALLEGHENY
WHITING, MD, R KEITH	LEBANON
WHITMAN, JAMES F	STUDENT
WHITMAN, MD, MARC S	PHILADELPHIA
WHITMAN, MD, MARK A	BUCKS
WHITMAN, MD, RANDAL L	PHILADELPHIA
WHITMAN, MD, ROBERT S	ALLEGHENY
WHITMONT, MD, RONALD D	DELAWARE
WHITMORE, MD, JOHN T	BEDFORD
WHITMORE, MD, MASON	DELAWARE
WHITNEY, MD, JONATHAN P	DAUPHIN
WHITNEY, MD, MARK B	CUMBERLAND
WHITSON, MD, DAVID W	LEHIGH
WHITTAKER, MD, RICHARD P	MONTGOMERY
WHITTLE, MD, DONNA I	ALLEGHENY
WHOLEY, MD, MARK H	ALLEGHENY
WHORRAL, MD, GREG S	ALLEGHENY
WHYTE, MD, JOHN	PHILADELPHIA
WHYTE, JOHN J	STUDENT
WIBLE, MD, CLAIRE E	YORK
WIBLE, MD, LEROY C	ALLEGHENY
WICKRAMASINGHE, MD, EARDLY K	ERIE
WIDDOWSON, MD, HAROLD R	DELAWARE
WIDELITZ, MD, MARTIN M	PHILADELPHIA
WIDER, MD, SAUL	PHILADELPHIA
WIDGE, MD, TOERUNA S	LEHIGH
WIDGER, MD, JOHN E	COLUMBIA
WIDLAN, MD, SHELDON	WESTMORELAND
WIDRA, MD, ERIC A	PHILADELPHIA
WIECKS, MD, MICHAEL J	DAUPHIN
WIEDER JR, MD, HENRY S	PHILADELPHIA
WIEGAND, MD, DAVID A	DAUPHIN
WIEGAND, ROSEMARY A	STUDENT
WIEMANN, MD, GEORGE F	BUCKS
WIENER, ETHAN S	STUDENT
WIENER, MD, EUGENE S	ALLEGHENY
WIENER, MD, JACOB S	PHILADELPHIA
WIENER, DO, STEPHEN D	MONTGOMERY
WIENER, MD, STEPHEN G	BERKS
WIERCISIEWSKI, MD, DAVID R	ALLEGHENY
WIESENFELD, MD, NATHANIEL H	LUZERNE
WIESNER, MD, IRVING S	DELAWARE
WIEST, MD, HIRAM L	DAUPHIN
WIGERT, MD, WALTER S	TIOGA
WIGHT, MD, SUSAN C	PHILADELPHIA
WIGLE, MD, ARNOLD R	WESTMORELAND
WIKLER, MD, LOUIS A	PHILADELPHIA
WIKLER, MD, MATTHEW A	PHILADELPHIA
WIKOFF, MD, EDWARD K	PHILADELPHIA
WILBERGER JR, MD, JAMES E	ALLEGHENY
WILBRAHAM, STEVEN C	STUDENT
WILBUR, MD, SABRINA L	PHILADELPHIA
WILCHER, MD, JOHN S	ALLEGHENY
WILCOX, MD, GEOFFREY H	ALLEGHENY
WILCOX, MD, KENNETH R	LACKAWANNA
WILCOX, MD, MARK S	ALLEGHENY
WILCOX JR, MD, WINTHROP P	LANCASTER
WILCZANSKI, MD, PETER L	ERIE
WILD JR, MD, ROBERT M	CENTRE
WILDBLOOD, MD, HARRY M	YORK
WILDENHAIN, MD, PHILIP M	ALLEGHENY
WILDENHAIN, MD, SARAH L	ALLEGHENY
WILDER, MD, BRUCE L	ALLEGHENY
WILDERMAN, MD, BARRY S	BUCKS
WILDRICK, MD, KENNETH H	NORTHAMPTON
WILEN, MD, HOWARD O	ALLEGHENY
WILEY, MD, BERT C	BLAIR
WILEY, DO, DAVID E	LANCASTER
WILEY, MD, LEE A	ERIE
WILF, MD, HAROLD	PHILADELPHIA
WILGUCKI, DO, JOHN D	LUZERNE
WILHELM, MD, BARBARA E	FAYETTE
WILHELM, MD, WILLIAM C	ERIE
WILKENING, MD, ROBIN M	MIFFLIN/JUNI
WILKENS, JILL C	STUDENT
WILKERSON, MD, L DOUGLAS	MONTGOMERY
WILKINS, MD, BYRON D	LEHIGH
WILKINS, MD, H JEFFREY	MONTGOMERY
WILKINSON, MD, DAVID M	MONTOUR
WILKINSON, MD, HAROLD A	DELAWARE
WILKINSON, MD, JOHN H	ALLEGHENY
WILKINSON, JOHN J	STUDENT
WILKINSON, MICHELLE E	STUDENT
WILKINSON, MD, ROSELISE H	DELAWARE
WILKS, MD, DAVID H	ALLEGHENY
WILLARD III, MD, WILLIS W	CUMBERLAND
WILLENBORG, MD, ANNE	CENTRE
WILLET, MD, ANDREW A	GREENE
WILLIAMS, MD, A CLAUDE	LYCOMING
WILLIAMS, MD, ANDRE' O	CHESTER
WILLIAMS, MD, BARBARA J	MONTGOMERY
WILLIAMS, MD, BONNIE M	ERIE
WILLIAMS, MD, BRENDA A	ALLEGHENY
WILLIAMS, MD, BRIAN A	ALLEGHENY
WILLIAMS, MD, BURTON L	DELAWARE
WILLIAMS, MD, CAROL C	MIFFLIN/JUNI
WILLIAMS, MD, CLAUDE M	DELAWARE
WILLIAMS, DO, DALE L	MERCER
WILLIAMS, DO, DAVID T	CAMBRIA
WILLIAMS, MD, F MARIAN	PHILADELPHIA
WILLIAMS, MD, GAYLE A	ALLEGHENY
WILLIAMS, MD, GLENN R	YORK
WILLIAMS, MD, HENRY N	LANCASTER
WILLIAMS, MD, HERMAN J	BERKS
WILLIAMS, MD, JAMES R	PHILADELPHIA
WILLIAMS, MD, JAMES W	DAUPHIN
WILLIAMS, MD, JAY JAMES	PHILADELPHIA
WILLIAMS, MD, JOHN J	BERKS
WILLIAMS, MD, JOHN T	PHILADELPHIA
WILLIAMS, MD, KAREN A	PHILADELPHIA
WILLIAMS, MD, KARL E	ALLEGHENY
WILLIAMS, MD, KATHERINE V	ALLEGHENY
WILLIAMS, KEITH N	STUDENT
WILLIAMS, MD, KIRKLEY R	PHILADELPHIA
WILLIAMS, MD, LYNN R	MONTGOMERY
WILLIAMS, DO, MARK S	WESTMORELAND
WILLIAMS, MD, MELVIN C	INDIANA
WILLIAMS, MD, NORMAN S	ALLEGHENY
WILLIAMS, DO, PAUL D	DAUPHIN
WILLIAMS, MD, R HALLOCK	MONTGOMERY
WILLIAMS, MD, RICHARD A	ERIE
WILLIAMS, MD, RICHARD G	ALLEGHENY
WILLIAMS, MD, RONALD J	DAUPHIN
WILLIAMS, MD, SCOTT L	ALLEGHENY
WILLIAMS, MD, SHELLEY D	ALLEGHENY
WILLIAMS, MD, STEPHEN K	MONTGOMERY
WILLIAMS, MD, SUSAN L	DELAWARE
WILLIAMS, MD, VIRGINIA M	DAUPHIN
WILLIAMS III, MD, IRVING	UNION
WILLIAMS JR, MD, GERALD R	PHILADELPHIA
WILLIAMS JR, MD, PHILIP D	ALLEGHENY
WILLIAMS JR, MD, THOMAS L	NORTHAMPTON
WILLIAMSON, MD, CLARKE E	PHILADELPHIA
WILLIAMSON, MD, EDWARD L	WESTMORELAND
WILLIAMSON, MD, MARK E	ALLEGHENY
WILLIAMSON, MD, NEIHL J	LYCOMING
WILLIG, MD, DORIS	PHILADELPHIA
WILLIHNGANZ, MD, WALTER D	BUCKS
WILLIS, PAUL M	STUDENT
WILLISON, MD, ROBERT W	ALLEGHENY
WILLNER, MD, DAVID L	CHESTER
WILLNER, MD, IRA R	PHILADELPHIA
WILLNER, MD, JAY	LUZERNE
WILLOCHELL, TERI A	STUDENT
WILLS, MD, CHERYL D	ALLEGHENY
WILLS, MD, MICHAEL H	LANCASTER
WILLWERTH, MD, GERALD E	FRANKLIN
WILSON, MD, ARTHUR R	ARMSTRONG
WILSON, MD, DAVID G	YORK
WILSON, MD, DAVID O	ALLEGHENY
WILSON, DO, DENISE M	MONTOUR
WILSON, MD, DONALD F	CHESTER
WILSON, MD, DOROTHY G	NORTHMBRLAND
WILSON, MD, DOUGLAS G	ALLEGHENY
WILSON, MD, ERIC P	DAUPHIN
WILSON, DO, FREDERICK R	MERCER
WILSON, MD, FREDERICK S	MONTGOMERY
WILSON, MD, GEORGE M	PHILADELPHIA
WILSON, MD, GEORGE W	ALLEGHENY
WILSON, MD, J EDWARD	DAUPHIN
WILSON, MD, JAMES A	LANCASTER
WILSON, MD, JAMES L	TIOGA
WILSON, MD, JEFFREY C	ALLEGHENY
WILSON, MD, JOHN A	ALLEGHENY
WILSON, DO, JOHN E	STUDENT
WILSON, MD, JOHN F	PHILADELPHIA
WILSON, MD, JOHN S	WESTMORELAND
WILSON, MD, LANCE B	BUCKS
WILSON, MD, LINDA C	CHESTER
WILSON, MD, RAY A	YORK
WILSON, MD, RICHARD A	ARMSTRONG
WILSON, MD, RICHARD C	LEHIGH
WILSON, MD, RICHARD P	PHILADELPHIA
WILSON, MD, ROBERT J	ALLEGHENY
WILSON, MD, ROBERT V	YORK
WILSON, MD, RUTH W	BEAVER
WILSON, MD, SAMUEL M	PHILADELPHIA
WILSON, STEPHEN A	STUDENT
WILSON, MD, THOMAS W	LAWRENCE
WILSON, MD, W LAWRENCE	ALLEGHENY

WILSON, MD, WILLIAM W	MONTGOMERY
WILSON JR, MD, CHARLES R	ALLEGHENY
WILSON JR, MD, ROBERT N	MONTGOMERY
WILT, MD, KENNETH E	YORK
WINANS, MD, LEWIS E	BERKS
WINEBERG, JENNIFER R	STUDENT
WINER, MD, JOEL W	YORK
WINER, LISA A	STUDENT
WINER, MD, STEPHEN F	LEBANON
WINEY, MD, WILFRED H	CAMBRIA
WINFREE, MD, LISTERVELT S	PHILADELPHIA
WING, MD, EDWARD J	ALLEGHENY
WINGARD, MD, LARRY B	ARMSTRONG
WINGATE, MD, GARY F	CHESTER
WINGERD, MD, ROBERT A	FRANKLIN
WINGERT JR, MD, CHARLES H	CENTRE
WINGERT JR, MD, J PAUL	BLAIR
WINIARSKI, MD, GENEVIEVE C	LANCASTER
WINIARSKI, MD, JANUSZ	BLAIR
WINKLER, MD, MARTIN	ALLEGHENY
WINKLER JR, MD, LOUIS H	NORTHAMPTON
WINN, MD, RANDALL S	BERKS
WINN JR, MD, CHARLES L	BUCKS
WINNEG, MD, KAREN P	BUCKS
WINSLOW, MD, ROY E	FRANKLIN
WINSON, MD, SAMUEL G	PHILADELPHIA
WINSTON, MD, BRADLEY M	DELAWARE
WINSTON, MD, JOSEPH M	BERKS
WINSTON, MD, NORMAN J	BERKS
WINSTON, MD, RALPH B	BRADFORD
WINT, MD, ROGER M	PHILADELPHIA
WINTER, MD, CHARLES R	LANCASTER
WINTER, MD, FRED S	MONTGOMERY
WINTER, MD, PETER M	ALLEGHENY
WINTER II, MD, JOHN C	LYCOMING
WINTERS, ELIZABETH A M	STUDENT
WINZELBERG, MD, GARY G	ALLEGHENY
WIRE, MD, WILBUR H	YORK
WIRSHUP, MD, MARY B	CHESTER
WIRTH, MD, TIMOTHY M	BERKS
WIRTS JR, MD, C WILMER	PHILADELPHIA
WISE, MD, RICHARD J	LUZERNE
WISEMAN, MD, BARBARA L	BRADFORD
WISEMAN, DO, DOUGLAS C	NORTHAMPTON
WISEMAN, MD, JEFFREY S	BRADFORD
WISGO, CHRISTOPHER J	STUDENT
WISHNEV, MD, MARTIN A	ALLEGHENY
WISMAN, MD, CRAIG B	DAUPHIN
WISNIEWSKI, MD, PETER M	LUZERNE
WISNIEWSKI, RALPH M	STUDENT
WISS, MD, RAYMOND J	CUMBERLAND
WISSEL, MD, PAUL S	MONTGOMERY
WISSINGER, MD, H ANDREW	ALLEGHENY
WISSLER, MD, ROBERT U	LANCASTER
WITHAM, MD, REBECCA S	DELAWARE
WITHERSPOON, MD, JOHN S	ALLEGHENY
WITHERSPOON, MD, ROBERT G	WESTMORELAND
WITHINGTON, MD, AMELIA M	PHILADELPHIA
WITKES, DO, DAVID M	CAMBRIA
WITKIN, MD, EVELYN D	MONTGOMERY
WITKOWSKI, MD, JOSEPH A	PHILADELPHIA
WITKOWSKI, MD, MARK T	BLAIR
WITKOWSKI, MD, THOMAS A	PHILADELPHIA
WITMER, MD, DONALD B	LANCASTER
WITMER, MD, ROBERT H	LANCASTER
WITOWSKI, MD, JOHN J	LACKAWANNA
WITT, MD, PAUL J	LUZERNE
WITTELS, MD, EMANUEL	BERKS
WITTELS, MD, HEIDI L	PHILADELPHIA
WITTERHOLT, MD, KENNETH A	CHESTER
WITTHOFF JR, MD, ELMER M	LYCOMING
WITTIG, MD, ROBERT L	ALLEGHENY
WITTMANN, MD, THOMAS A	ERIE
WIVELL, MD, WAYNE A	STUDENT
WIZDA, MD, MARIANNE	ALLEGHENY
WODLINGER, MD, PAUL M	WASHINGTON
WODNICKI, MD, MOISES	WASHINGTON
WODZINSKI, MD, STEVEN F	WESTMORELAND
WOEHLING, MD, JOANNE K	DELAWARE
WOEL, BERENGERE S	STUDENT
WOELFEL, MD, GEORGE F	ALLEGHENY
WOERTHWEIN, MD, KENNETH F	YORK
WOHL, MD, MILTON A	PHILADELPHIA
WOHL-KRISTO, MD, CATHERINE V	DELAWARE
WOJCIAK, DO, RAYMOND J	ALLEGHENY
WOLANIN, MD, JANUSZ	LUZERNE
WOLBACH JR, MD, ALBERT B	LANCASTER
WOLDORF, MD, NORMAN M	DAUPHIN
WOLDOW, MD, ANDREW B	MONTGOMERY
WOLDOW, MD, ASHER	PHILADELPHIA
WOLF, ABIGAIL	STUDENT
WOLF, MD, CHARLES R	CHESTER
WOLF, CINDY J	STUDENT
WOLF, ERICA	STUDENT
WOLF, MD, FRANKLIN M	BERKS
WOLF, MD, LAURENCE R	MONTGOMERY
WOLF, LAWRENCE B	STUDENT
WOLF, MD, LEWIS R	PHILADELPHIA
WOLF, MD, MELVYN A	MONTGOMERY
WOLF, MD, NELSON M	PHILADELPHIA
WOLF, MD, RICHARD M	PHILADELPHIA
WOLF, ROBERT S	STUDENT
WOLF, MD, SANDRA M	PHILADELPHIA
WOLF, MD, STEWART G	NORTHAMPTON
WOLF III, ALBERT A	STUDENT
WOLF JR, MD, JOHN H	PHILADELPHIA
WOLFE, MD, DANIEL E	LYCOMING
WOLFE, MD, DAVID W	BRADFORD
WOLFE, MD, DWIGHT D	LANCASTER
WOLFE, MD, JUDITH A	CAMBRIA
WOLFE, MD, PATRICK W	CAMBRIA
WOLFERT, MD, IRWIN H	MONTGOMERY
WOLFERTH JR, MD, CHARLES C	PHILADELPHIA
WOLFF, MD, CHARLES R	ALLEGHENY
WOLFF, MD, DANIEL C	SUSQUEHANNA
WOLFF, MD, JEFFREY M	WESTMORELAND
WOLFF, MD, REGIS A	ALLEGHENY
WOLFGANG, CHRISTOPHER	STUDENT
WOLFGANG, MD, GARY L	MONTOUR
WOLFINGER, MD, WALTER L	FRANKLIN
WOLFORD, MD, JACK A	ALLEGHENY
WOLFSON, MD, BERNARD	ALLEGHENY
WOLFSON, MD, PHILIP J	PHILADELPHIA
WOLFSON, MD, ROBERT J	PHILADELPHIA
WOLFSON, MD, STEVEN J	LYCOMING
WOLFSON JR, MD, SIDNEY K	ALLEGHENY
WOLGEMUTH JR, MD, JOHN M	LANCASTER
WOLGIN, MD, WILLIAM	PHILADELPHIA
WOLINSKY, MD, ARTHUR P	ALLEGHENY
WOLK, MD, DANIEL L	DELAWARE
WOLK, MD, MELVYN H	LACKAWANNA
WOLK, MD, MICHAEL D	LACKAWANNA
WOLK, MD, STEPHEN M	LUZERNE
WOLK, MD, THOMAS A	CHESTER
WOLLMAN, MD, HARRY	PHILADELPHIA
WOLLMAN, MD, MICHAEL R	ALLEGHENY
WOLMARK, MD, NORMAN	ALLEGHENY
WOLOSHIN, MD, HENRY J	PHILADELPHIA
WOLYNN, MD, TODD H	STUDENT
WOMACK, LAWRENCE H	STUDENT
WON, MD, A W PETER	ERIE
WON, MD, KWAN H	DAUPHIN
WON, MD, OKHEE	LACKAWANNA
WONDERLICK, MD, EUGENE L	MONTOUR
WONG, MD, ALBERT	SOMERSET
WONG, MD, ALEXANDER	SUSQUEHANNA
WONG, MD, ALFONSO MING Y	PHILADELPHIA
WONG, MD, EDGAR	TIOGA
WONG, EDMOND Y	STUDENT
WONG, MD, HENRY C	MONROE
WONG, MD, HON YUEN	CLARION
WONG, MD, JAMES	BERKS
WONG, MD, JAMES M	ALLEGHENY
WONG, KATHLEEN M	STUDENT
WONG, MD, LING G	CENTRE
WONG, MD, MING-DER	YORK
WONGPAKDEE, MD, SOBSAN	POTTER
WONSETTLER, MD, DONALD E	MERCER
WOO, MD, MARIANO	YORK
WOO, MD, Y JOSEPH	STUDENT
WOOD, MD, DAVID W	MONTGOMERY
WOOD, MD, ERNEST M	LANCASTER
WOOD, MD, HOWARD P	MONTGOMERY
WOOD, MD, JAMES E	PHILADELPHIA
WOOD, MD, JOHN M	ALLEGHENY
WOOD, LAURA M	STUDENT
WOOD, MD, MADELINE S	DELAWARE
WOOD, MD, MOIRA D	PHILADELPHIA
WOOD, RANDOLPH B	STUDENT
WOOD, MD, SANDRA D	ALLEGHENY
WOODARD, MD, L LEE	ALLEGHENY
WOODBURY, DEBORAH	STUDENT
WOODEN, MD, WILLIAM A	ALLEGHENY
WOODINGS, MD, SAMUEL G	MERCER
WOODLE, DO, EDWARD M	INDIANA
WOODLEY, MD, CHRISTOPHER C	LACKAWANNA
WOODMAN, MD, THOMAS J	BUCKS
WOODRING, MD, ALBERT J	MONTGOMERY
WOODRUFF, MD, CHARLES L	PHILADELPHIA
WOODRUFF JR, MD, D STRATTON	MONTGOMERY
WOODS, MD, ANNE N	YORK
WOODS, MD, EDWARD L	UNION
WOODS, KELLY W	STUDENT
WOODS, MD, TIMOTHY A	PHILADELPHIA
WOODSIDE, MD, JOHN A	YORK
WOODSON, MD, ROBERT H	PHILADELPHIA
WOODWARD, MD, EDWARD G	DAUPHIN
WOODWARD, MD, JOHN P	PHILADELPHIA
WOODWARD, MD, MARK A	MONROE
WOOLCOCK, MD, RUTH B	INDIANA
WOOLLEY JR, MD, PAUL O	CENTRE
WOOLSLAYER, MD, PAUL R	SOMERSET
WOOMERT, MD, CATHLEEN A	DAUPHIN
WOOTEN, MD, SALLY M	MIFFLIN/JUNI
WORKMAN, CHERYL A	STUDENT
WORKS, MD, KIRK L	MERCER
WORLEY, MD, CARL M	ALLEGHENY
WORLEY, MD, SETH J	LANCASTER
WORMUTH, CHRISTOPHER J	STUDENT
WORMUTH, SEAN	STUDENT
WORNAS, MD, CHRISTIAN G	BERKS
WOROBEC, MD, RUSSELL N	LYCOMING
WORRALL, MD, V THOMAS	ALLEGHENY
WORRILOW, MD, SUZANNE H	LEBANON
WORSHTIL, MD, MARK E	WASHINGTON
WORTHINGTON, MD, JOHN J	MONTGOMERY
WORTZEL, MD, RICHARD D	BUCKS
WORTZEL, MD, SANDRA H	BUCKS
WOTRING, MD, JOHN M	BERKS
WOWK, MD, VICTOR A	LYCOMING
WOYNAROWSKI, MD, DAVID M	BERKS
WOYNAROWSKI, MD, JOHN A	BERKS
WOZNIAK, MD, JOHN	DELAWARE
WOZNIAK, MD, RICHARD S	CAMBRIA
WRIGHT, MD, BRUCE A	ALLEGHENY
WRIGHT, MD, DAVID G	ALLEGHENY
WRIGHT, MD, DEBORAH S	BUCKS
WRIGHT, MD, DONALD C	ALLEGHENY
WRIGHT, MD, FAY D	PHILADELPHIA
WRIGHT, MD, L ALAN	ALLEGHENY
WRIGHT, MD, LANCE S	PHILADELPHIA
WRIGHT, MD, RAYFORD E	CAMBRIA
WRIGHT, MD, RICHARD E	ALLEGHENY
WRIGHT, MD, ROBERT E	LACKAWANNA
WRIGHT, MD, SCOTT H	PHILADELPHIA
WRIGHT, MD, THOMAS S	MONTGOMERY
WRIGHT, MD, WILLIAM C	COLUMBIA
WRIGHT, MD, WILLIAM R	LAWRENCE
WRIGHT JR, MD, ALFRED E	FAYETTE
WRIGHT JR, MD, GEORGE J	ALLEGHENY
WRIGHT JR, MD, JOHN C Y	BEAVER
WRIGLEY, MD, MICHAEL S	MONTGOMERY
WROBLEWSKI, MD, GENEVIEVE A	LUZERNE
WU, MD, CHAU H	ELK/CAMERON
WU, MD, CHRISTINE	PHILADELPHIA
WU, HSI-YANG	STUDENT
WU, MD, JUN-YI	LACKAWANNA
WU, KENNETH D	STUDENT
WU, LILLIAN	STUDENT
WU, PETER C	STUDENT
WU, MD, TSUNG-TEH	ALLEGHENY
WUKICH, MD, DANE K	NORTHAMPTON
WULC, MD, ALLAN E	BERKS
WULFMAN, MD, JEFFREY S	MONTOUR
WUMMER, MD, BRIAN A	BERKS
WUSHENSKY, MD, CURTIS A	CHESTER
WUSTROW, MD, H JUERGEN	BLAIR
WUSYLKO, MD, MICHAEL	ALLEGHENY
WYATT, MD, RICHARD M	PHILADELPHIA
WYBLE, CHARLES W	STUDENT
WYDAN, MD, ANTHONY G	MONTGOMERY
WYLIE, MD, MARY E	ALLEGHENY
WYLONIS, LAUREN J	STUDENT
WYNERT, MD, WILLIAM R	CAMBRIA
WYNKOOP, WALTER A	STUDENT
WYSHOCK, MD, EDWARD G	LYCOMING
WYSZOMIERSKI, MD, DAVID A	WESTMORELAND
WYSZYNSKI, DO, EUGENE J	PHILADELPHIA
WYTOCK, MD, DALE H	MONTOUR

X

XANTHOPOULOS, DO, JAMES E	MIFFLIN/JUNI
XAVIER, MD, CHERIAN P	PHILADELPHIA

Y

YACONO, MD, JOHN V	ALLEGHENY
YAGNIK, MD, PRATAP M	DELAWARE
YAGNIK, MD, REKHA P	DELAWARE
YAKIN, DAVID E	STUDENT
YAKISH, MD, JACK E	ERIE
YAKISH, MD, SAMUEL D	BEAVER
YAMULLA, MD, ROBERT S	LUZERNE
YAMULLA, MD, STANLEY J	LUZERNE
YAN, ALBERT C	STUDENT
YANCEY, MD, MICHAEL V	BRADFORD
YANCICH, DO, LOUIS A	LYCOMING
YANG, MD, JAE-TAEK	ARMSTRONG
YANG, MD, JAU-HSIN	ALLEGHENY
YANG, LYNN W	STUDENT
YANG, MD, SHUIN-LIN	PHILADELPHIA
YANG, MD, SUSAN T	MONTGOMERY
YANG, THOMAS S	STUDENT
YANG, MD, UN-TAEK	MONTGOMERY
YANG, MD, WEN-SHIONG	LEHIGH
YANG, MD, WILLIAN	MONTGOMERY
YANICKO JR, MD, DANIEL R	MERCER
YANITY, MD, EUGENE J	MONTGOMERY
YANKELEVICH, MD, RAUL	PHILADELPHIA
YANKURA, MD, JOHN A	ALLEGHENY
YANNACCONE, MD, ROBERT	UNION
YANNI, MD, ANTHONY J	STUDENT
YANOFF, MD, DAVID B	LEHIGH
YANOFF, MD, MYRON	PHILADELPHIA
YANOFSKY, MD, CHARLES S	DAUPHIN
YANOSHAK, DO, ROBERT N	LUZERNE
YANOVIAK, DO, FRANCIS J	UNION
YANOVIAK, MD, PAMELA W	UNION
YANOVSKI, MD, A VIVIAN	PHILADELPHIA
YANOVSKI, MD, ALEXANDER G	PHILADELPHIA
YANOVSKI, MD, JACK A	PHILADELPHIA
YANUS, BARBARA J	STUDENT
YAP, MD, WEN T	MONTOUR
YARBORO, MD, THEODORE L	MERCER
YARBORO JR, MD, THEODORE L	STUDENT
YARCZOWER, MD, BRET S	LUZERNE
YARDLEY, MD, TREVOR W	CAMBRIA
YARDNEY, MD, MARC J	DELAWARE
YARIAN, MD, DAVID O	BEAVER
YARNALL, MD, G WINFIELD	DAUPHIN
YARON, MD, NOEMI S	DELAWARE
YAROS, MD, JOHN G	ALLEGHENY
YAROS, MD, MARK F	SOMERSET
YAROSH, CHERYLON A	STUDENT
YARRA, MD, NIRMALA	PHILADELPHIA
YARROW, MD, MORRIS W	PHILADELPHIA
YARTZ, DO, FRANK C	MONTOUR
YARUS, DO, LANCE O	LEBANON
YARZE, MD, JOSEPH C	BRADFORD
YASUI, MD, ROBERT S	LYCOMING
YASWINSKI JR, MD, PETER T	MONROE
YATES, MD, ADOLPH J	ALLEGHENY
YATES, MD, ANTHONY P	ALLEGHENY
YATES, MD, JAMES A	DAUPHIN
YATES, MD, WILLIAM A	CAMBRIA
YAVIL, DO, JULES S	PHILADELPHIA
YAVOREK, MD, AMY	LACKAWANNA
YAW, MD, KENNETH M	ALLEGHENY
YAZDANFAR, MD, SHAHRIAR	PHILADELPHIA
YAZDANYAR, MD, ALI	BUCKS
YAZDI, SHAHRAD	STUDENT
YEAGER, MD, BRADFORD A	LEHIGH
YEAGER, MD, HENRY C	LACKAWANNA
YEAGER, MD, JAMES P	CUMBERLAND
YEAGLEY, MD, HEBER E	BERKS
YEAKEL, MD, ALLEN E	LANCASTER
YEALY, MD, W HOLMES	LYCOMING
YEAMANS, MD, BRUCE E	LEBANON
YEASTED, MD, G ALAN	ALLEGHENY
YEAW, MD, SCOTT C	NORTHAMPTON
YEE, MD, DANA A	BEAVER
YEE, MD, MARIA R	PHILADELPHIA
YEE, REBECCA	STUDENT
YEH, ROBERT M	STUDENT
YEISLEY, MD, GEARY L	LEHIGH
YELLENIK, MD, ANDREW C	ALLEGHENY
YEN, MD, CONCEPTION T	LEHIGH
YEN, DENIS A	STUDENT
YEOMAN, MD, MARGARET P	DELAWARE
YERGER, MD, JOHN F	CAMBRIA
YETSCONISH, MD, CHARLES A	ALLEGHENY
YEVELSON, DO, STANLEY A	NORTHAMPTON
YEVITZ, MD, WILLIAM J	LACKAWANNA
YI, HYO G	STUDENT
YIM, MD, BELINDA YUN-MAE	MONTGOMERY
YIM, KENNETH B	STUDENT
YIN, MD, ELAINE	PHILADELPHIA
YING, MD, SHUN C	ALLEGHENY
YINGLING, MD, BRYAN L	LANCASTER
YINGVORAPANT, MD, SOMCHAO	ALLEGHENY
YIP, MD, LUKE C	LEHIGH
YIP, MARGIE D	STUDENT
YOANIDIS, NANCY R	STUDENT
YOCKEY, MD, ROBERT H	ARMSTRONG
YOCUM, DO, MARTIN D	LEBANON
YODER, MD, DELBERT L	SOMERSET
YODER, MD, JOHN J	LANCASTER
YODER, MD, MORRIS L	DELAWARE
YODER, MD, STANLEY J	CENTRE
YODER, MD, STEPHEN E	PHILADELPHIA
YOH, MD, HAROLD N	BERKS
YOHE, MD, WILLIAM C	YORK
YOO, MD, HO JOON	ERIE
YOO, MD, HOON	WAYNE/PIKE
YOO, PETER J	STUDENT
YOO, MD, TAI Y	JEFFERSON
YOO, MD, YOUNG-KUL	LUZERNE
YOON, MD, CHAN	LYCOMING
YOON, MD, CHUNG H	PHILADELPHIA
YOON, MD, DONALD D	WESTMORELAND
YOON, MI-YUNG	STUDENT
YOON, MD, MYUNG S	LUZERNE
YOSKIN, MAURICE P	STUDENT
YOSKOSKY, JAMIE D	STUDENT
YOST, MD, CHARLES S	COLUMBIA
YOST, MD, RICHARD O	ALLEGHENY
YOST, ROBERT B	STUDENT
YOST, MD, ROBERT M	MONTGOMERY
YOUKEY, MD, JERRY R	MONTOUR
YOUN, MD, BRIAN A	MONTOUR
YOUN, PETER Y	STUDENT
YOUNES, MD, MAMDOUH S	YORK
YOUNG, MD, ADRIENNE M	ALLEGHENY
YOUNG, MD, CHENG DONG	ALLEGHENY
YOUNG, DO, DAVID J	BUCKS
YOUNG, MD, DONNA C	ALLEGHENY
YOUNG, MD, ELIZABETH A	ALLEGHENY
YOUNG, MD, GERALDINE P	PHILADELPHIA
YOUNG, MD, IN MIN	MONTGOMERY
YOUNG, MD, IRVING	PHILADELPHIA
YOUNG, MD, JAMES F	LANCASTER
YOUNG, MD, JANET E	PHILADELPHIA
YOUNG, MD, JOHN J	MONTGOMERY
YOUNG, MD, JOSEPH M	WESTMORELAND
YOUNG, MD, LINDA L	ERIE
YOUNG, MD, MURIEL L	PHILADELPHIA
YOUNG, MD, NANCY ANNE	PHILADELPHIA
YOUNG, DO, STEVEN M	LUZERNE
YOUNG, MD, TERRI L	PHILADELPHIA
YOUNG, MD, THOMAS A	BRADFORD
YOUNG, MD, THOMAS E	NORTHAMPTON
YOUNG, MD, WILLIAM B	PHILADELPHIA
YOUNG, DO, WILLIAM E	CENTRE
YOUNG, MD, WILLIAM W	DAUPHIN
YOUNG, MD, WILLIAM W	LANCASTER
YOUNGBERG, MD, RUSSELL E	BERKS
YOUNGKIN, MD, JAMES F	COLUMBIA
YOUSHAW, MD, DENNIS G	BLAIR
YOUSSEF, MD, NAWAL A	MONTGOMERY
YOUSSEF, MD, SOHEIR	PHILADELPHIA
YOW, MD, MICHAEL V	DELAWARE
YOXTHEIMER, MD, ROBERT L	CHESTER
YSLA, MD, ROY G	YORK
YU, MD, PAUL T	NORTHAMPTON
YUCHA, MD, THOMAS J	DAUPHIN
YUDIS, MD, MELVIN	MONTGOMERY
YUEN, MD, ALBERT	BERKS
YUHAS, MD, THOMAS R	DAUPHIN
YUKEVICH, MD, JOHN P	BEAVER
YUM, MD, KEUK Y	DELAWARE
YUMANG, MD, NORBERTO Y	LAWRENCE
YUMEN, MD, OMAR	MONTOUR
YUN, MD, DANIEL D	PHILADELPHIA
YUN, ELIZABETH S	STUDENT
YUN, MD, JAE K	ERIE
YUN, MD, WON K	LEBANON
YUNGINGER, MD, RICHARD C	LANCASTER
YUNIS, MD, JORGE J	PHILADELPHIA
YURICK, MD, NATALIE A	CHESTER
YUSSEN, MD, PHILIP S	PHILADELPHIA

Z

ZABAD, MD, HUSSEIN A J	PHILADELPHIA
ZABALA-OMBAO, MD, LOURDES A	BUCKS
ZABEL, DO, CHRISTINE M	DELAWARE
ZACHER, MD, JOSEPH A	CARBON
ZACHIAN, MD, VICTOR A	PHILADELPHIA
ZADEH, MD, MEHDI L	ERIE
ZAEPFEL, MD, JOSEPH P	LANCASTER
ZAFAR, MD, GHAFFAR A	SCHUYLKILL
ZAGER, MD, ERIC L	PHILADELPHIA
ZAGER, MD, MICHAEL L	LEHIGH
ZAGLAMA, MD, NABIL E	FAYETTE
ZAGURSKY, MD, JOYCE A	DELAWARE
ZAHABI-UNWALA, MD, FEHMIDA	ALLEGHENY
ZAHORCHAK, MD, JOSEPH A	ALLEGHENY
ZAIDAN, MD, JAMES G	FAYETTE
ZAIMES, MD, JEANETTE M S	PHILADELPHIA
ZAITOON, MD, MOHAMMAD M	WESTMORELAND
ZAJAC, MD, ANDREJ J	LACKAWANNA
ZAKEOSIAN, MD, GARABET M	DELAWARE
ZAKHARY, MD, GEORGE S	SCHUYLKILL
ZAKRZEWSKI, MD, KEVIN M	PHILADELPHIA
ZAKRZEWSKI, DO, MICHAEL J	MONTGOMERY
ZALATIMO, MD, AKRAM A	LUZERNE
ZALE, MD, ANTHONY G	LACKAWANNA
ZALE, NANNETTE R	STUDENT
ZAMBARANO, MD, THOMAS J	DAUPHIN
ZAMBELLI JR, MD, GEORGE R	BEAVER
ZAMMERILLA, MD, CHARLES A	FAYETTE
ZAMOSTIEN, MD, BERNARD B	PHILADELPHIA
ZAMOSTIEN, MD, PAUL S	DELAWARE
ZAMPAGLIONE, EDIO J	STUDENT
ZANGRILLI, MD, JAMES G	ALLEGHENY
ZANGWILL, MD, BRUCE C	PHILADELPHIA
ZANGWILL, MD, DONALD P	ALLEGHENY
ZANKMAN, DO, GREGG S	BUCKS
ZANKMAN, MD, NATHAN	BUCKS
ZAPATA, MD, WILLIAM A	BERKS
ZAPOTOK, DAWN M	STUDENT
ZAPP, MD, JOHN J	ALLEGHENY
ZAPPALA, DO, ANGELO J	BUCKS
ZARATE, MD, MARIA PAZ A	GREENE
ZAREN, MD, HOWARD A	PHILADELPHIA
ZARFOS, MD, MORGAN L	YORK
ZARGE, MD, JOSEPH I	PHILADELPHIA
ZARNICK, MD, PHILIP D	ALLEGHENY
ZARRELLI, MD, STEPHEN G	MONTGOMERY
ZASIK JR, DO, JOSEPH M	NORTHAMPTON
ZASLAU, STANLEY	STUDENT
ZATUCHNI, MD, JACOB	PHILADELPHIA
ZAVADAK, MD, DANIEL G	ALLEGHENY
ZAVAHIR, MD, M FEIZAL	BLAIR
ZAVARAS, MD, KATERINA A	ALLEGHENY
ZAVATSKY, MD, ALBERT R	BERKS
ZAVITSANOS, MD, GEORGE P	PHILADELPHIA
ZAYDON, MD, ANNE C	LACKAWANNA
ZDUNEK, DO, JAY R	BEAVER
ZECCARDI, MD, JOSEPH A	PHILADELPHIA
ZEE, MD, MARY K	DELAWARE
ZEGEL, MD, HARRY G	PHILADELPHIA
ZEGLEN, MD, ARTHUR F	WAYNE/PIKE
ZEGLEN, MD, KURT T	LACKAWANNA
ZEHEL, MD, WENDELL E	ALLEGHENY
ZEHNER, MD, JAMES M	VENANGO
ZEHNER, MD, JANET A	VENANGO
ZEHNER, MD, LUTHER R	CRAWFORD
ZEHR, MD, RALPH D	BRADFORD
ZEI, MD, JULIANNA M	BERKS
ZEIDAN, MD, ZEIDAN F	YORK
ZEIDMAN, MD, JOAN H	PHILADELPHIA
ZEIGEN, MD, SCOTT R	BUCKS
ZEIGLER, MD, DAVID C	CENTRE
ZEIGLER JR, MD, MAURICE L	DAUPHIN
ZEILER, MD, WILLIAM B	ALLEGHENY
ZEINER, MD, GEORGE B	DELAWARE
ZEIT, MD, ROBERT M	PHILADELPHIA
ZEITLIN, MD, MARK H	ERIE
ZEITZER, MD, KENNETH L	PHILADELPHIA
ZEITZER, RANDI J	STUDENT
ZELAC, DANIEL E	STUDENT
ZELAHY JR, JOHN W	STUDENT
ZELECHOSKI, MD, DAVID M	CLINTON
ZELEN, MD, RANDY S	CRAWFORD
ZELESNICK, MD, GABRIEL	YORK
ZELEZNIK, MD, MIROSLAV	WESTMORELAND
ZELIGER, DO, BERNARD I	DAUPHIN
ZELINSKY JR, MD, JOSEPH J	STUDENT
ZELKOVIC, MD, AUDREY A	ALLEGHENY
ZELLER, MD, ERWIN R	CHESTER
ZELLER, MD, HARRY R	ALLEGHENY
ZELLER, MD, ROBERT G	LYCOMING
ZELLEY, MD, LEE S	MONTGOMERY
ZELLIS, DO, JOSEPH	PHILADELPHIA
ZELLIS, DO, SHARON L	PHILADELPHIA
ZELNICK, MD, ERIC B	BERKS
ZELT, MD, ROGER P	ALLEGHENY
ZEMBLE, DO, HERBERT A	PHILADELPHIA
ZEMEL, MD, WALTER G	BUCKS
ZEMO, MD, PETER L	YORK
ZENEL JR, MD, JOSEPH A	YORK
ZENKER, MD, JOANNE S	LACKAWANNA
ZERBONIA, DO, ANGELO N	ERIE
ZERBY, MD, JEFFREY C	BERKS
ZERITSKY, MD, SAMUEL	PHILADELPHIA
ZERNE, MD, G EDWARD	CHESTER
ZERNICH, DO, GREGG S	BEAVER
ZERNICH, MD, MICHAEL R	BEAVER
ZERNICH, MD, MILAS	ALLEGHENY
ZERNICH, MD, WALLACE	BEAVER
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WHEN ACID REFLUX ERUPTS

Zantac® 150 Tablets
(ranitidine hydrochloride)

BRIEF SUMMARY

Zantac® 300 Tablets
(ranitidine hydrochloride)

Zantac® Syrup
(ranitidine hydrochloride)

The following is a brief summary only. Before prescribing, see complete prescribing information in Zantac® product labeling.

INDICATIONS AND USAGE: Zantac® is indicated in:
1. Short-term treatment of **active duodenal ulcer.** Most patients heal within 4 weeks.
2. **Maintenance therapy** for duodenal ulcer patients at reduced dosage after healing of acute ulcers.
3. The treatment of **pathological hypersecretory conditions** (e.g., Zollinger-Ellison syndrome and systemic mastocytosis).
4. Short-term treatment of **active, benign gastric ulcer.** Most patients heal within 6 weeks and the usefulness of further treatment has not been demonstrated.
5. Treatment of **gastroesophageal reflux disease (GERD).** Symptomatic relief commonly occurs within 1 or 2 weeks after starting therapy. Therapy for longer than 6 weeks has not been studied.

In active duodenal ulcer; active, benign gastric ulcer; hypersecretory states; and GERD, concomitant antacids should be given as needed for relief of pain.

CONTRAINDICATIONS: Zantac® is contraindicated for patients known to have hypersensitivity to the drug.

PRECAUTIONS:

General: 1. Symptomatic response to Zantac® therapy does not preclude the presence of gastric malignancy.
2. Since Zantac is excreted primarily by the kidney, dosage should be adjusted in patients with impaired renal function (see DOSAGE AND ADMINISTRATION). Caution should be observed in patients with hepatic dysfunction since Zantac is metabolized in the liver

Laboratory Tests: False-positive tests for urine protein with Multistix® may occur during Zantac therapy, and therefore testing with sulfosalicylic acid is recommended.

Drug Interactions: Although Zantac has been reported to bind weakly to cytochrome P-450 *in vitro*, recommended doses of the drug do not inhibit the action of the cytochrome P-450-linked oxygenase enzymes in the liver. However, there have been isolated reports of drug interactions that suggest that Zantac may affect the bioavailability of certain drugs by some mechanism as yet unidentified (e.g., a pH-dependent effect on absorption or a change in volume of distribution).

Increased or decreased prothrombin times have been reported during concurrent use of ranitidine and warfarin. However, in human pharmacokinetic studies with dosages of ranitidine up to 400 mg per day, no interaction occurred; ranitidine had no effect on warfarin clearance or prothrombin time. The possibility of an interaction with warfarin at dosages of ranitidine higher than 400 mg per day has not been investigated.

Carcinogenesis, Mutagenesis, Impairment of Fertility: There was no indication of tumorigenic or carcinogenic effects in lifespan studies in mice and rats at dosages up to 2,000 mg/kg per day.

Ranitidine was not mutagenic in standard bacterial tests (*Salmonella, Escherichia coli*) for mutagenicity at concentrations up to the maximum recommended for these assays.

In a dominant lethal assay, a single oral dose of 1,000 mg/kg to male rats was without effect on the outcome of two matings per week for the next 9 weeks.

Pregnancy: ***Teratogenic Effects: Pregnancy Category B:*** Reproduction studies have been performed in rats and rabbits at doses up to 160 times the human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Zantac. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: Zantac is secreted in human milk. Caution should be exercised when Zantac is administered to a nursing mother.

Pediatric Use: Safety and effectiveness in children have not been established.

Use in Elderly Patients: Ulcer healing rates in elderly patients (65 to 82 years of age) were no different from those in younger age-groups. The incidence rates for adverse events and laboratory abnormalities were also not different from those seen in other age-groups.

ADVERSE REACTIONS: The following have been reported as events in clinical trials or in the routine management of patients treated with Zantac®. The relationship to Zantac therapy has been unclear in many cases. Headache, sometimes severe, seems to be related to Zantac administration.

Central Nervous System: Rarely, malaise, dizziness, somnolence, insomnia, and vertigo. Rare cases of reversible mental confusion, agitation, depression, and hallucinations have been reported, predominantly in severely ill elderly patients. Rare cases of reversible blurred vision suggestive of a change in accommodation have been reported.

Cardiovascular: As with other H_2-blockers, rare reports of arrhythmias such as tachycardia, bradycardia, atrioventricular block, and premature ventricular beats.

Gastrointestinal: Constipation, diarrhea, nausea/vomiting, abdominal discomfort/pain, and rare reports of pancreatitis.

Hepatic: In normal volunteers, SGPT values were increased to at least twice the pretreatment levels in 6 of 12 subjects receiving 100 mg q.i.d. intravenously for 7 days, and in 4 of 24 subjects receiving 50 mg q.i.d. intravenously for 5 days. There have been occasional reports of hepatitis, hepatocellular or hepatocanalicular or mixed, with or without jaundice. In such circumstances, ranitidine should be immediately discontinued. These events are usually reversible, but in exceedingly rare circumstances death has occurred.

Musculoskeletal: Rare reports of arthralgias.

Hematologic: Blood count changes (leukopenia, granulocytopenia, thrombocytopenia) have occurred in a few patients. These were usually reversible. Rare cases of agranulocytosis, pancytopenia, sometimes with marrow hypoplasia, and aplastic anemia and exceedingly rare cases of acquired immune hemolytic anemia have been reported.

Endocrine: Controlled studies in animals and man have shown no stimulation of any pituitary hormone by Zantac® (ranitidine HCl) and no antiandrogenic activity, and cimetidine-induced gynecomastia and impotence in hypersecretory patients have resolved when Zantac has been substituted. However, occasional cases of gynecomastia, impotence, and loss of libido have been reported in male patients receiving Zantac, but the incidence did not differ from that in the general population.

Integumentary: Rash, including rare cases suggestive of mild erythema multiforme, and, rarely, alopecia.

Other: Rare cases of hypersensitivity reactions (e.g., bronchospasm, fever, rash, eosinophilia), anaphylaxis, angioneurotic edema, and small increases in serum creatinine.

OVERDOSAGE: Information concerning possible overdosage and its treatment appears in the full prescribing information.

DOSAGE AND ADMINISTRATION: (See complete prescribing information in Zantac® product labeling.)

Active Duodenal Ulcer: The current recommended adult oral dosage is 150 mg or 10 mL (2 teaspoonfuls equivalent to 150 mg of ranitidine) twice daily. An alternate dosage of 300 mg or 20 mL (4 teaspoonfuls equivalent to 300 mg of ranitidine) once daily at bedtime can be used for patients in whom dosing convenience is important. The advantages of one treatment regimen compared to the other in a particular patient population have yet to be demonstrated.

Maintenance Therapy: The current recommended adult oral dosage is 150 mg or 10 mL (2 teaspoonfuls equivalent to 150 mg of ranitidine) at bedtime.

Pathological Hypersecretory Conditions (such as Zollinger-Ellison syndrome): The current recommended adult oral dosage is 150 mg or 10 mL (2 teaspoonfuls equivalent to 150 mg of ranitidine) twice a day. In some patients it may be necessary to administer Zantac® 150-mg doses more frequently. Dosages should be adjusted to individual patient needs, and should continue as long as clinically indicated. Dosages up to 6 g per day have been employed in patients with severe disease.

Benign Gastric Ulcer: The current recommended adult oral dosage is 150 mg or 10 mL (2 teaspoonfuls equivalent to 150 mg of ranitidine) twice a day.

GERD: The current recommended adult oral dosage is 150 mg or 10 mL (2 teaspoonfuls equivalent to 150 mg of ranitidine) twice a day.

Dosage Adjustment for Patients with Impaired Renal Function: On the basis of experience with a group of subjects with severely impaired renal function treated with Zantac, the recommended dosage in patients with a creatinine clearance less than 50 mL/min is 150 mg or 10 mL (2 teaspoonfuls equivalent to 150 mg of ranitidine) every 24 hours. Should the patient's condition require, the frequency of dosing may be increased to every 12 hours or even further with caution. Hemodialysis reduces the level of circulating ranitidine. Ideally, the dosing schedule should be adjusted so that the timing of a scheduled dose coincides with the end of hemodialysis.

HOW SUPPLIED: Zantac® 300 Tablets (ranitidine hydrochloride equivalent to 300 mg of ranitidine) are yellow, capsule-shaped tablets embossed with "ZANTAC 300" on one side and "Glaxo" on the other. They are available in bottles of 30 (NDC 0173-0393-40) tablets and unit dose packs of 100 (NDC 0173-0393-47) tablets.

Zantac® 150 Tablets (ranitidine hydrochloride equivalent to 150 mg of ranitidine) are white tablets embossed with "ZANTAC 150" on one side and "Glaxo" on the other. They are available in bottles of 60 (NDC 0173-0344-42) and 100 (NDC 0173-0344-09) tablets and unit dose packs of 100 (NDC 0173-0344-47) tablets.

Store between 15° and 30°C (59° and 86°F) in a dry place. Protect from light. Replace cap securely after each opening.

Zantac® Syrup, a clear, peppermint-flavored liquid, contains 16.8 mg of ranitidine hydrochloride equivalent to 15 mg of ranitidine per 1 mL in bottles of 16 fluid ounces (one pint) (NDC 0173-0383-54).

Store between 4° and 25°C (39° and 77°F). Dispense in tight, light-resistant containers as defined in the USP/NF.

September 1991

Glaxo Pharmaceuticals™
DIVISION OF GLAXO INC.
Research Triangle Park, NC 27709

Zantac® Syrup:
Manufactured by Roxane Laboratories, Inc., Columbus, OH 43216

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Zantac® Tablets
ranitidine HCl/Glaxo 150 mg tablets bid
WHEN ACID REFLUX ERUPTS
Please see Brief Summary of Prescribing Information on adjacent page.
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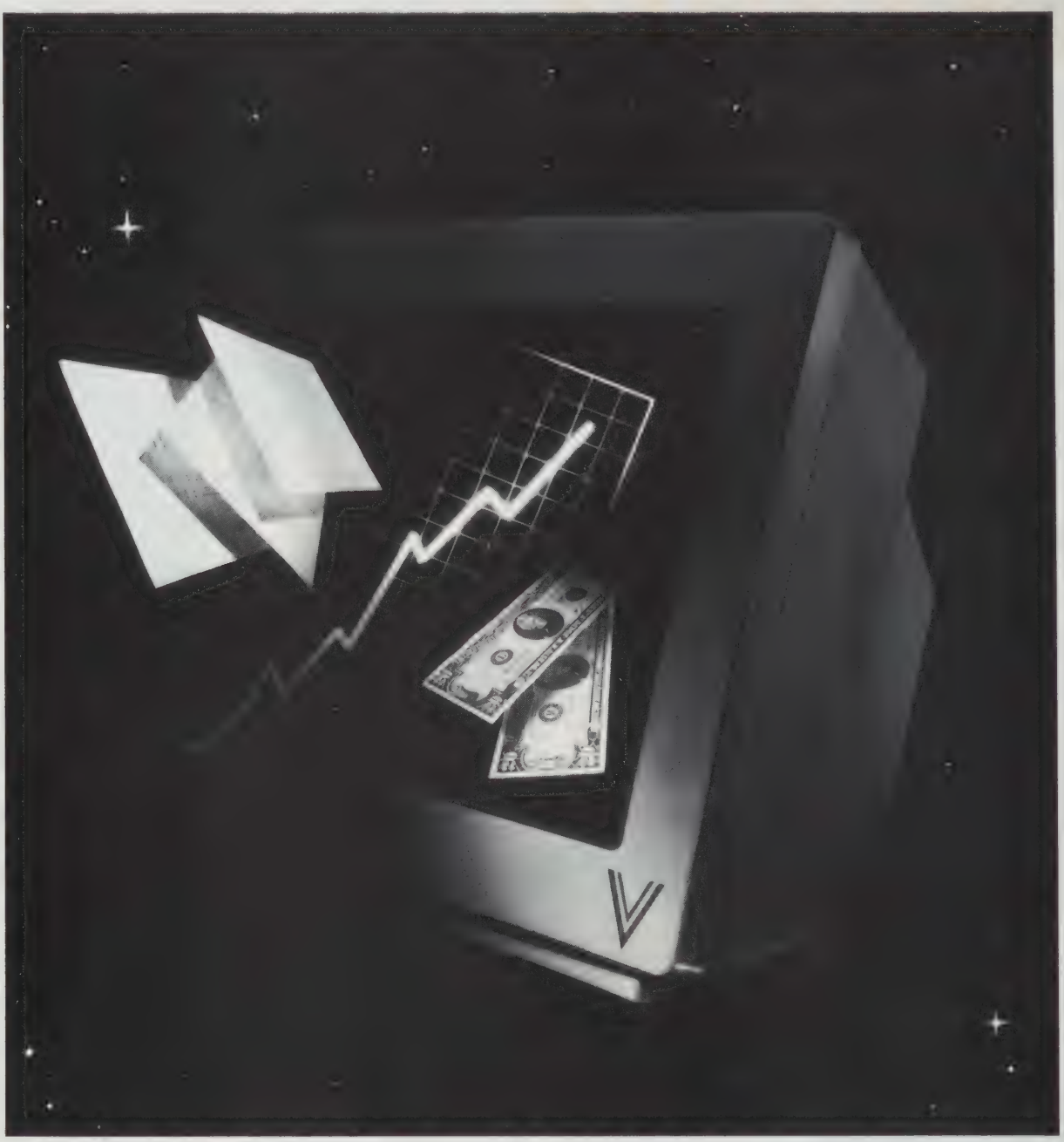
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SEPTEMBER 1992



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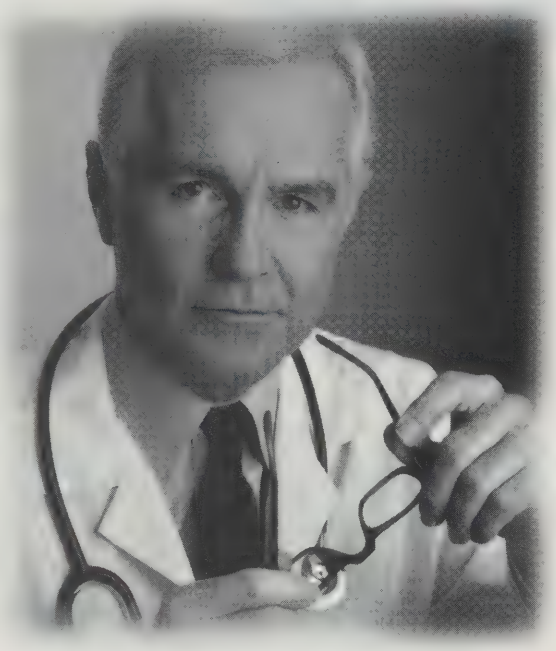
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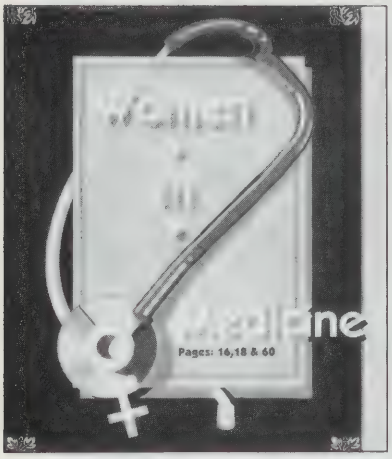
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Women in Medicine

In honor of Women in Medicine Month, celebrated each September, this issue of PENNSYLVANIA MEDICINE contains several articles addressing the realities and future possibilities for female physicians and minority physicians. Also included are national and state statistics on the issue, as well as information about related Society activities.

Cover design by SpectraComp

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Legacy and Future—*page 16*

Women at the Top: Liability Insurance With Innovation—*page 18*

Future Possibilities—*page 60*

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Many physicians will encounter the use of durable powers of attorney in medical practice as patients become more informed and more prepared for end-of-life decisions. This article differentiates the durable power of attorney and the living will, and explains the authority granted to the DPA holder.

> *"While both are considered types of advance directives, a durable power of attorney differs from and is not interchangeable with a living will."*

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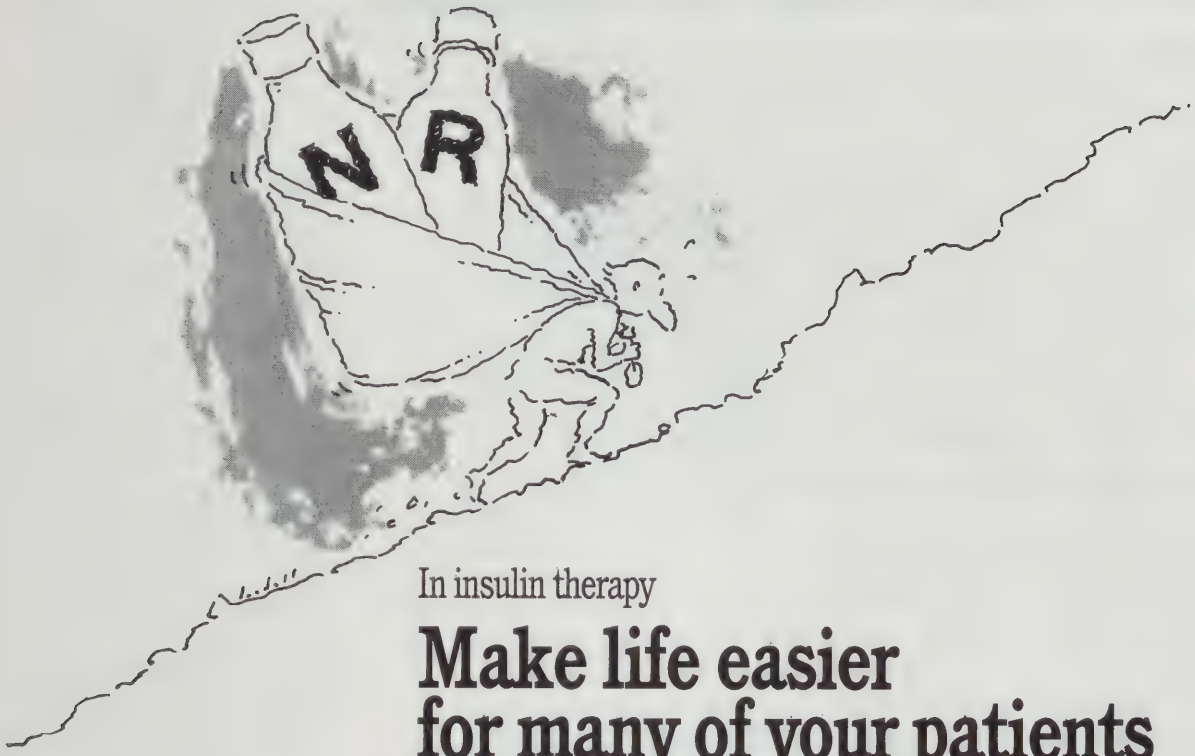
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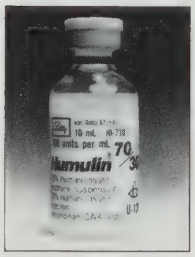
PENNSYLVANIA MEDICINE (ISSN 0031-4595) is published monthly by the Pennsylvania Medical Society, 777 East Park Drive, Harrisburg, PA 17111.
SUBSCRIPTIONS: $20 per year— United States and Canada; $30—all others. Single issues $3.00 per copy prepaid; special issues cost more.
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MEDIGRAM

GOVERNOR CUTS WELFARE BENEFITS, SOCIETY RESPONDS: Governor Robert P. Casey announced in late July a plan to cut Medical Assistance benefits for approximately 80,000 recipients of General Assistance. The state proposes to institute an 18-medical-visit-per-year limit and a coupon payment system. Final draft regulations released August 12 also propose to eliminate routine dental services to adult welfare recipients. The governor has opted for a regulatory route that bypasses the legislature. The State Society responded by: 1) providing input at a September 2 Independent Regulatory Review Commission public hearing; 2) working with the Department of Public Welfare to address concerns over the means by which restrictions will be accomplished and monitored; and 3) suggesting which medical conditions should be included in a list of exemptions from the 18-visit-per-year proposed limit. At press time, the Society was planning how to advise the membership on the new rules, which may take effect October 1.

SOCIETY MEETS WITH SECRETARY OF AGING ABOUT PACE: State Society Vice President Martin A. Murcek, MD, and other Society representatives met with Secretary of Aging Linda Rhodes in mid-August to discuss the Society's concerns with proposed cuts to the state's Pharmaceutical Assistance Contract for the Elderly (PACE) program. The Society sent a follow-up letter to Secretary Rhodes outlining commitments made at the meeting, and it will continue to try to keep communications with Aging open. For more information, see page 36.

CLIA STANDARDS, ENFORCEMENT EFFECTIVE SEPTEMBER 1: Quality standards and enforcement regulations implementing the Clinical Laboratory Improvement Act of 1988 (CLIA) became effective September 1. Physicians who have not filed a Health Care Financing Administration (HCFA) 109 form should do so immediately so that HCFA may assign a CLIA number and continue to pay claims without delay. HCFA has said as long as a physician's application is in process, and the physician has a personal identification number (PIN) and "remains active" in the administration's computer, claims will continue to be paid. Physicians with questions regarding their CLIA status should call the CLIA inquiry hotline at (410) 290-5850.

HOUSE OF DELEGATES CONVENES OCTOBER 23-25: The Pennsylvania Medical Society's House of Delegates will meet for its annual business meeting October 23-25 at the Adam's Mark Hotel, Philadelphia. A special feature this year will be a forum on health care reform scheduled for Friday. President Elect Donald G. Ferguson, MD, will be installed as president Saturday evening. The deadline for submitting resolutions is September 23.

STATE LEADERS INVITED TO MEET WITH GOVERNOR ON WORKERS' COMP: House and Senate leaders have been invited to meet with Governor Casey in mid-September to discuss possible resolution of pending workers' compensation legislation. The Society maintains that it will support concurrence in the Senate amendments to House Bill 2140, Printer's Number 3913 (see Government, page 31).

NOONAN SWORN IN AS HEALTH SECRETARY: Allan S. Noonan, MD, MPH, was officially sworn in as Pennsylvania's Secretary of Health on August 13, 1992. He has been acting health secretary since October 1, 1991.

CONGRESS VOTES ON "GAG RULE," ANIMAL PROTECTION ACT: The U.S. House of Representatives in early August voted 251-144 to overturn the "gag rule" that restricts abortion information at federally funded family planning clinics. The vote was short of the number of votes needed to override an expected Bush veto. The bill now goes to the Senate where passage is likely. Also in August, the House and Senate passed the Animal Enterprise Protection Act of 1992, legislation that provides criminal penalties for acts of violence against research efforts. The bill has been sent to the President for approval; there has been no indication to date that he will veto the bill.

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ELECTRONIC SERVICES

Reflections On Our First Board Retreat

John W. Mills, MD
Medical Editor

"All physicians, not just the Board members, need to take the time for some self-examination... and have the grace to know where our expertise lies."

Between the House of Delegates meetings each October, your Board of Trustees wrestles with some very sticky issues in trying to provide strong leadership to the State Society.

This has become a formidable task. Many issues facing our profession today require intensive study; consultation with experts on aspects of medicine or socio-economics in which we, as physicians, are not specialists; and many hours of probing debate in order to arrive at defensible positions. These positions must then be promoted to the legislature and to the citizens of the Commonwealth as our leadership stance. But I know that, as a Board, we're not always going to bat 100 percent—who does?

The Board meets formally about seven times each year, but early this July we met for a separate "retreat". For over a year, we had batted around the idea of a retreat—a session set aside from the often jam-packed agendas of complex Society business and dedicated to more in-depth discussions, self-examination, and personal soul-searching.

While our first attempt was too formal for my taste, I hope subsequent "retreats" will offer even more time for self-examination and discussion. We heard formal presentations on extremely important topics such as health care reform, legislative effectiveness, and Society structure. We listened, questioned the experts, discussed the issues. We tried to grasp and digest as much as possible. And while we have to stand for re-election, like the legislature, that doesn't occupy a priority position in our deliberations. We put leadership above re-election because that's why we chose to serve on the Society's Board in the first place.

Several things kept recurring throughout the retreat. They're basic, but so important that I believe they should be of more than passing interest to readers:

• *Image*: Of the State Society, of organized medicine, and of the profession. The State Society is still viewed as an all-white, male organization, partly because our Board is just that. This issue of PENNSYLVANIA MEDICINE is devoted in part to "women in medicine"—something our Board now lacks, since two Board seats formerly filled by women were assumed this year by men. The presence of Dr. Betty Cottle, who was a trustee for nine years, has been especially missed.

We have a credible Board doing a good job—but that's not enough to project an image that reflects our membership today. And it's not enough to attract a broad, changing spectrum of membership. We need some diversity on the Board to dispell that mirror-image stereotype of the make-up of Society membership.

Recruitment of women and minority members is a top priority this year. But we also need to encourage their participation and volunteerism, and place them in leadership positions.

• *Grassroots lobbying*: We talked about how to improve our efforts in the legislative arenas, but formal lobbying is only part of the picture. Our Senators and Representatives need to hear from each Society member on a regular basis, not only about specific issues and bills, but also on a personal level, about what it's like to practice medicine in this difficult time, about our personal concerns for public health and welfare.

• *Grassroots activism*: Looking at the "big" issues facing the Society only emphasizes more the importance of individual members, not how important Board decisions are. Each physician needs to become involved in lobbying, recruiting members, and helping to decide policies affecting the future of medicine.

Remember this basic tenant: physicians know how to manage illness and treat patients. But we are also well-educated citizens who carry a responsibility to use that education to understand the issues and become active in our local communities.

All physicians, not just the Board members, need to take the time for some self-examination...and have the grace to know where our expertise lies.



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Commencement

Robert N. Moyers, MD



As students return to their classrooms this month, I am reminded of how honored I feel to have been elected to a three-year term on the American Medical Association's Council on Medical Education at the AMA's 1992 annual meeting. At the same time, Lee H. McCormick, MD, was elected chairman of the AMA's Hospital Medical Staff Section, and Maria Simbra was elected to the national governing council of the Medical Student Section.

As the practicing physician representative to the medical education council, I have the chance to make a difference by carrying the thinking of Pennsylvania's physicians to the national agenda. I also will bring to the table insights gained from an active practice and from what I've learned at the Pennsylvania Medical Society over the years.

Self-governance is the hallmark of any profession, yet in medical education, as in other areas of medicine, non-physicians are seeking to make more of the rules. Here in Pennsylvania, our governor has warned that the Commonwealth's medical schools should produce more family physicians or risk losing state funding. The mix of physician specialties concerns us all, but it is physicians, not government, who should be out in front, working to ensure that our medical schools meet the needs of patients in the years ahead.

Pennsylvania's medical schools function according to their own unique needs and concerns, and we would certainly not want to see a "one-size-fits-all" approach. Nevertheless, we who are in the front lines of medical care delivery must work to narrow the gap between academia and private practice. We have mutual goals; unity, not fragmentation, will make those goals achievable.

Lines are being drawn at the national level. The Council of Graduate Medical Education, which is appointed by Congress, said it would like to see 50 percent of all residents in primary care medicine. Last March, the Association of Professors of Medicine endorsed a similar goal—that half of internal medicine residents should be generalists. That same month, the U.S. Bureau of Health Professions called for 50 percent of all residents to be in primary care by the year 2000.

But even today, many primary care residencies go unfilled. Will government legislate quotas? Medical schools are testing curriculum reform, but they cannot, and should not, control their students' choices. It's clear that the best solution for our profession is based on incentives and encouragement from within: today's physicians reaching out to tomorrow's.

Specialty mix is one educational concern. Medical student debt is another. The average debt for a medical student is now more than $46,000. A new federal law has addressed some issues of loan deferment and forbearance, but there are ways physicians can help. This year, the Society's Educational and Scientific Trust has outstanding loans of nearly $480,000 to 197 medical and allied health students. These are *your* contributions at work to help *your* future colleagues.

We need to see changes in resident hours to create more humane and ultimately more productive working conditions. We need to facilitate the licensing and acceptance of qualified international medical graduates and work against even subtle discriminatory attitudes and practices. Also, we are concerned about continuing medical education (CME) and are working to uphold high standards in the granting of CME credits.

I see my role on the council during the next three years as a great opportunity for Pennsylvania physicians to influence national policy on these and other important issues in medical education. Education and ethics are the two foundations of organized medicine. Our hopes for the future of our profession rest in our students; and the future of our students and patients rests on the quality and integrity of our academic system.



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LETTERS TO THE EDITOR

OBJECTION VOICED TO LEADERSHIP STRUCTURE

At the 1992 Leadership Conference of the Pennsylvania Medical Society, our president, Robert N. Moyers, MD, called for greater participation by physicians in the affairs and activities of the Society. Such a goal is both logical and worthy, as well as necessary, if physicians and patients are to be preserved from the pressures being brought by government. There is little argument or discussion that could dissuade one from trying to attain this valuable goal.

A review of the current structure of the Pennsylvania Medical Society, including boards, the AMA delegation, councils, and committees, indicates that there are 358 positions in the hierarchy of the Society which can be held by physicians. Each physician in a State Society position can contribute significantly to Society strength in three ways:

1) The physician brings his or her ideas to the State Society and adds to the total "knowledge pool" available to solve problems.

2) The physician at work in his or her home area is an ambassador of the Pennsylvania Medical Society, able to better explain what the State Society does, able to better recruit new members, and able to better act as a liaison when the member at home has a question or a problem.

3) Last, but not least, by direct involvement in activities of the State Society, the physician is one more member with a better grasp on the problems of medicine, and the physician is more effective as a direct contact person with members of the legislature.

Thus, in a society with over 20,000 members, surely we will have 358 individual doctors involved in these positions. As Dr. Moyers has recommended, we should encourage the maximum number of physicians to participate directly in the affairs of the Society.

But we don't do that! Sixty (60) people hold a total of 182 positions. *Yes...60 people...182 positions.* An average of three-plus positions per person. Over 50 percent of all positions held by just 60 people. What one finds is: 35 persons with two positions; 10 persons with three positions; three persons with four positions; seven persons with five positions; four persons with six positions; and would *you believe*, one person with 11 positions!

Granted, isn't it nice that so few are willing to do so much for so many? And granted, that while not every position requires a lot of time, many are very time consuming. But considering the problems we are having, shouldn't we be utilizing the interest and intelligence of as many different doctors as possible? I suggest we need all the help we can get. We have 240 doctors working in Society positions. Let's add another 120 doctors. Let's give our president what he asked for: the help, the support, and the involvement of as many physician members as possible.

Charles Heisterkamp III, MD, FACS
Lancaster

Editor's Note: Dr. Heisterkamp's letter was further researched by him and also by your medical editor. As noted below, the majority of positions in the Pennsylvania Medical Society are appointed as follows: by the president-elect—130, by the Board of Trustees—65, by the chairman of the board—65, and by the speaker of the house—7. The remainder, 83, are elected by the House of Delegates, for a total of 358 positions.

Dr. Heisterkamp neglected to include a number of positions which are appointed by the speaker of the house each year, namely members of Reference, Rules, and Credentials committees, as well as the tellers. In addition, each separate section of the Society (medical student, resident physician, young physician, HMSS, and interspecialty) elects their own boards from their delegates. So, in reality we have about 1,000 individual physicians involved directly in the business of the State Society. If you also count all the delegates and special committees, plus the boards of KePRO, PMSLIC, and The Educational and Scientific Trust, that figures to about one-twentieth of the membership—not bad, I'd say!

The Society's by-laws mandate many positions, including three others held by the secretary. The by-laws also are quite definite about who appoints the various committees and councils, both of the House and the Board.

Each year the president elect sends to each trustee and component medical society a request for names of members who would be willing to serve on councils and committees. The number of responses is usually abysmal. Perhaps that's the reason the by-laws stipulate a six-year limit for service on a council or commission. Also note:

- *Four of seven members with five positions are board members, three are not.*
- *All of the members with six positions are board members.*
- *Six of the members with five or six positions have at least two positions elected by the House.*
- *The secretary with 11 positions should be understandable.*

Dr. Murcek will be looking for volunteers early next year as the president elect. The chairman of the board and the speaker of the house are also in need of volunteers annually. Please call them and indicate your interest or expertise.

And finally, the House of Delegates may amend the by-laws any time they see fit.

John W. Mills, MD
Medical Editor

DEA NUMBERS: STATE SPECIFIC OR NOT?

I am writing in reference to the response by Medical Editor John W. Mills, MD, to the Letters to the Editor section in the April issue of PENNSYLVANIA MEDICINE. Dr. Mills made the statement that DEA numbers are not state specific. I do not believe this is, in fact, the case based upon my experience with the state of New Jersey and their requirements for narcotic registration. I was required to have federal DEA registration for the state of New Jersey, in addition to the one I had in the state of Pennsylvania, for the many years of my practice. The substance of my communications on this matter was that the federal DEA is issued for use in an individual state. This may or may not be a matter requiring further study or clarification for your readership.

Charles D. Tourtellotte, MD
Philadelphia

Editor's Note: According to DEA, the DEA identification number is unique and physician specific nationwide. It was explained that if a physician practices in two different states, the physician is assigned two different DEA numbers. Likewise, if a physician practices on two sites within the same state, he or she is assigned a number for each site. Thus, Dr. Mills and Dr. Tourtellotte are both

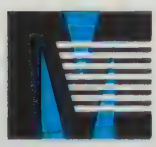
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correct: while the DEA number is not necessarily state specific, it is location *specific.*

IN SEARCH OF ASSISTANCE FOR CZECHOSLOVAKIA

Dr. Gordon MacLeod has suggested I write to PENNSYLVANIA MEDICINE to solicit the State Society's help in a project of mine. I recently visited Czechoslovakia under the auspices of the American Czechoslovak Society of Washington to identify possible projects for myself and for members of Pennsylvania's health care community to assist that country (perhaps soon to be two countries) in reforming and improving its health care system.

I visited a large number of health care facilities—large and small hospitals, specialty hospitals, and clinics—and met with many health care providers, including physicians, administrators, and nurses. Almost everyone expressed great interest in having visits from their peers in the United States to assist them in restructuring their delivery system, identifying ways to improve the delivery of care, and bringing them up-to-date on developments in their professional fields. For decades they have been severly limited in their ability to travel abroad, and the system has been so poorly funded that they haven't had access to journals and other means of keeping current in their specialties.

I wonder if the Pennsylvania Medical Society, through its publications, could alert the physicians and other providers in Pennsylvania of the need Czechoslovakia has for persons who might be willing to volunteer a couple of weeks, or longer if possible, to visit Czechoslovakia to conduct seminars and to consult one-on-one with their peers throughout the health care system. The Ministries of Health in both the Czech Republic (Prague) and Slovakia (Bratislova) would be more than willing to help with all arrangements or contacts.

This would be a volunteer effort, though the American Czechoslovak Society of Washington has a method of assuring that the expenses of volunteers are deductible. I feel certain that the hosts would be most helpful in arranging transport within the country, interpreter services, and perhaps in some cases accommodations in homes or staff residences.

A fringe benefit of such a commitment is the opportunity to see a beautiful and interesting country and to observe the dramatic changes that have been, and continue to be, taking place. Several Pittsburgh physicians have already volunteered. I'm sure they will have a rewarding experience.

If there is a way of advertising this opportunity of service to your members, the American Czechoslovak Society of Washington and I would much appreciate it. Interested persons could contact me at: 190 Crestvue Manor Drive, Pittsburgh, PA 15228, (412) 531-1764; or Mr. Charles Warr, Chairman, Health/Environment Committee, 2831 27th Street NW, Washington, DC 20008, (202) 265-4545, Fax - (202) 483-5323.

Thank you very much.

Frank S. Beal
Pittsburgh

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Disney Village Resort
Lake Buena Vista, FL
December 27-30, 1992

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February 12-14, 1993

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March 3, 1993

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March 26-28, 1993

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April 7, 1993

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April 28, 1993

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Legacy and Future

Doris G. Bartuska, MD, FACP

September is Women in Medicine Month and an appropriate time to recognize the heritage and the future of women physicians.

The number of women physicians in the United States has more than quadrupled since 1967. In 1990-91 there were 104,194 women physicians and 511,227 male physicians. More than 42 percent of all women physicians are under age 35, and 41 percent of all medical students are women. When I was a medical student, only six percent of medical students were women.

Women physicians are entering all specialties, including surgery, neurosurgery, plastic surgery, and orthopedics. The majority are in internal medicine, pediatrics, general and family practice, psychiatry, and obstetrics/gynecology.

Women physicians are receiving active support from state, county, and specialty societies to increase their involvement in organized medicine at the local and national levels. Organized medicine has much to gain from including women physicians in the mainstream. It also has much to lose if our creative ideas and women's and family health concerns are not aired and resolved on local and national policy agendas.

Where do women stand in academic medicine? Almost 19 percent of medical school faculty members are women, but 67 percent of those are in the entry-level ranks of assistant professor, research instructor, or clinical instructor.

In 1985, five percent of professors were women; in 1990, 9.5 percent were women. In 1991, there was one medical school woman dean.

Women students may find inspiration and role models more easily now that more women physicians are assuming leadership positions on medical school faculties. We are beginning to equalize the opportunities for women in medicine.

We must encourage our talented women physicians by recognition, support, and financial assistance to enter and succeed in academic careers. More academic women physicians should be in leadership roles—delivering scientific papers and chairing sessions at medical meetings, earning important positions in specialty societies, being politically active, chairing departments, being deans, and having a role in organized medicine to influence health care policy. Certainly, department chairs must monitor career paths and discuss the criteria for promotion in academic medicine with junior faculty members.

We *must* address the needs and concerns of our women physicians in solo and group practices. The American Medical Association database has important statistics. With regard to family characteristics, 77 percent of women physicians and 84 percent of male physicians under the age of 40 are married. Of these, 45 percent of the women and 10 percent of the men are married to physicians.

Women physicians work 47.2 weeks per year; male physicians work 47.4 weeks. While young women physicians work nearly a week less per year than young male physicians, mature women physicians work almost a week more than their male colleagues.

Regarding income, women physicians' income has been one-third less than men; however, in most primary care specialties, women's earnings and visit charges are within 10 percent of male physicians'.

The charge of the editor of PENNSYLVANIA MEDICINE requested personal vignettes from our women physicians. I was privileged to be one of 10 women physicians honored at the Women in Medicine dinner held during the 250th celebration of the founding of the University of Pennsylvania, where I did graduate education in molecular medicine. I quote from a citation I received there:

Dr. Bartuska has been active in organized medicine since her graduation from the Woman's Medical College of Pennsylvania (MCP) and continues to act as an advocate for women physicians as they attain

According to current Sate Society statistics, 8,039 women in Pennsylvania place an MD or DO after their name. An estimated 1,500 of those are residents.

Dr. Bartuska is professor of medicine and director, Division of Endocrinology, Diabetes and Metabolism, Medical College of Pennsylvania, Philadelphia; and vice chair of the Society's Educational and Scientific Trust. She is the mother of six children; her youngest is in the medical field.

major leadership positions in American medicine.

Dr. Bartuska was named Outstanding Educator of America; is a past associate dean of the Medical College of Pennsylvania; and has been named to the World Who's Who of Women in Education, Who's Who of American Women, and the World Who's Who of Women. She is past president as well as a delegate to the American Medical Women's Association.

Her research has been primarily in the area of endocrinology of aging with a special emphasis on prevention and treatment of osteoporosis. A major focus has been on the genetic and autoimmune polyglandular disorders that involve the thyroid, adrenal, and gonads.

Dr. Bartuska, the only woman to receive the Father Clarence E. Shaffrey Award from St. Joseph's University, is a "Distinguished Daughter of Pennsylvania," as cited by the governor, and is past president of the Philadelphia County Medical Society.

PENNSYLVANIA SPECIFICS

Population: 12,040,000▲

Number of active physicians: 35,000▲

Percentage of female physicians: 18%▲

Percentage of female physicians under 35: 57%▲

Percentage of 1992 medical school graduates who are female: 35%▲▲

▲ Source: *Physician Manpower in Pennsylvania: 1989*, © Pennsylvania Medical Society

▲▲ Source: PENNSYLVANIA MEDICINE, July 1992

SOCIETY PROJECTS HONOR WOMEN IN MEDICINE

AMA Board member Palma Formica, MD, was the featured speaker at a Pennsylvania Medical Society reception honoring women physicians. This year's reception was held at the Philadelphia County Medical Society on September 10. It was one of the State Society's special projects for Women in Medicine this month.

The Society's membership department, later this month, will launch a special recruitment effort aimed at increasing the number of women physicians in organized medicine.

For additional information about Women in Medicine month, call the Society's Division of Communications and Public Affairs at 1-800-228-7823.

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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

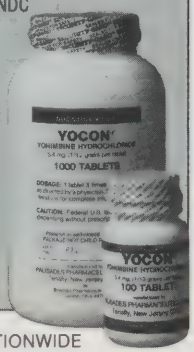
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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Women at the Top: Liability Insurance With Innovation

Maria T. Montesano
Assistant Managing Editor



Betty L. Cottle, MD



Sarah H. Lawhorne, JD

In light of Women in Medicine month, celebrated each September, PENNSYLVANIA MEDICINE takes a look at the two women at the helm of the State Society's Liability Insurance Company.

The Pennsylvania Medical Society Liability Insurance Company (PMSLIC) prides itself on leadership and innovation. In the medical profession, approximately 65 percent of those trained are men. Yet, two women of diverse backgrounds have been chosen to lead the doctor-run Society subsidiary offering liability coverage to more than 7,000 Pennsylvania physicians. Those women—Betty L. Cottle, MD, chairman of the board, and Sarah H. Lawhorne, JD, president and chief operating officer—along with a team of dedicated physicians and staff members, this year helped PMSLIC maintain its position as "the largest writer of individual physicians in the Commonwealth."

Dr. Cottle, a Hollidaysburg anethesiologist, became involved in PMSLIC in the early 1980s as a board member. At that time she was a member of the Society board who "saw the merits of the organization" and thought it served a purpose that she believed in. Today, as chairman of the board of PMSLIC, she wants to see the company "continue its tradition of excellence" and serve the changing needs of the physician: "We need to meet the challenges of changing medical practice, and protect physicians with insurance."

Dr. Cottle was born in St. Louis, Missouri, but moved to New York City at an early age. There she grew up and was educated, all along knowing she wanted to be a doctor. With the encouragement of her family, she pursued the field, but it was not an easy road for a woman during World War II: "Women were not that plentiful in the medical profession...there were a lot of problems in applying to medical school." Yet she persisted and was accepted to the New York University School of Medicine.

The ratio of male-to-female medical students at NYU at that time was approximately 32:1. According to Dr. Cottle, "It was lonesome and rough-going, but it was a wonderful experience." Remaining in New York for her residency, she chose anesthesiology as a specialty because it was the clinical application of the two sciences she most liked—pharmacology and physiology. She then went into private practice for 20 years in New York and held clinical teaching jobs. Of teaching, she says, "If you really believe the Hippocratic Oath, you really have to believe that you owe something back to the profession."

Dr. Cottle is a long-time leader of organized medicine. Her involvement began in 1952, when she joined the Kings County and New York Medical Societies, and the American Medical Association. Upon moving to Pennsylvania in 1970 with her husband and three children, she joined the Blair County Medical Society (BCMS) "to get to know the doctors in the town and to continue my relationship with organized medicine." Soon after joining, she was named BCMS secretary, and since then has held several positions, including membership on various State Society councils and committees, and as a delegate to the Society and the AMA. As for the nine years spent on the Pennsylvania Medical Society Board of Trustees, she says, "I enjoyed it. I enjoyed being able to participate in the process of the politics of medicine."

Dr. Cottle was appointed chairman of the PMSLIC board in April 1989. Her commitment to the company stems from her faith in it: "PMSLIC helps a physician in crisis—protects the physician, educates the physician, and upholds the high standards of medical practice. We will defend any doctor who practices good medicine." Lawhorne concurs, "What PMSLIC is trying to do is defend a doctor's right to a day in court, particularly when their medicine was right."

Lawhorne joined the company as secretary and general counsel in November 1980, was made a vice president in April 1990, and named president in September 1991, when PMSLIC's first president, John

Smither, retired. Originally from Delaware County, she graduated from Kalamazoo College, Michigan, with a degree in psychology. Hailing from a law family—her father is a lawyer, and her mother worked in the juvenile courts—she received her Juris Doctor from Hastings School of Law in San Francisco.

After law school, she returned to Pennsylvania to practice in her father's firm "just long enough to argue a murder case appeal to the Pennsylvania Supreme Court," she says. Feeling she was "riding" on her father's accomplishments, she started looking for other work and became assistant attorney general with the state's Medical CAT Fund. A year later, she was hired away from the fund by PMSLIC.

Of her commitment to the company, she says, "I did not go to law school to enter the business world. The fact that I've stayed at PMSLIC since 1980 is reflective of a couple of things—it's an insurance company with integrity, and what PMSLIC is trying to do makes sense to me."

She also credits the principle to defend doctors' rights and reform the system from within for her continued commitment: "John Smither, Dave Masland [past chairman of the board], and then Betty Cottle created an environment here that never got jaded...We have an extremely high level of awareness of our goal throughout the entire employee population." Such an awareness has helped Lawhorne encourage a sense of teamwork among employees in her first year as president.

"I have learned this past year that we have a superlative staff," she says. "As a colleague, I just saw the staff as how I related to them as legal counsel...But in the new position, I see them in their full light, and I am really impressed by the people we have." Lawhorne adds, "I think there's an on-going benefit to the fact that John [Smither] purposely hired people who didn't have medical malpractice insurance backgrounds. He didn't want to do things the way they had always been done...didn't want to be bound by the old patterns. I see that now, even though we've become quite expert and respected, there's still that creative edge; we all remember why we're here."

Under Lawhorne's direction, PMSLIC is implementing a new planning process: "We are breaking down departmental views, and we're looking at how we can do things better and where we want to be." But, she says, that doesn't discount where PMSLIC has come from. "We have stability and expertise, and it's having physician input and guidance—a physician board, a physician claims committee, access to the State Society—that really differentiates us in terms of what our product is."

Physician Claims Committee

In 1991, PMSLIC reviewed 1,056 medical malpractice claims. Of that number, 653 "smaller" cases were reviewed by individual PMSLIC board members or independent consultants. However, the other 403 claims required more intensive review due to their complexity and "more catastrophic nature." Enter the PMSLIC Claims Committee.

Eight physicians on PMSLIC's Board of Directors are assigned to the committee annually. According to Fred C. Thistle, vice president of claims at PMSLIC, the committee consists of members of several specialties and generally meets once a month to review, on the average, 25 cases. "There is a summary sheet for each case which gives a synopsis of the allegations, medical issues, and legal issues; and explains where the case is pending, who the plaintiff attorney is, who the defense attorney is, what the demand on the case is in terms of money, and so forth. This is accompanied by copies of medical records, test results, correspondence from defense expert counsel, and information about the insured's view of the case. The job of the Claims Committee," he continues, "is to analyze the information and make a decision as to whether each case is one to settle or defend. The review may be a one-shot procedure, or it may involve more than one review."

The review process contains extensive physician-communication measures; and for physicians who may disagree with the committee's decision, there is an appeals process. A PMSLIC-insured physician may be requested, or may request, to attend a Claims Committee meeting to present his or her position. If a lack of agreement still exists, the matter is referred to the Pennsylvania Medical Society Professional Liability Insurance Appeals Committee (PLIAC), which exists for the purpose of resolving disputes between PMSLIC and its policyholders. The decision of PLIAC is final and binding on both parties.

According to Thistle, "Only 19 claim disputes have been submitted to PLIAC in our entire history of nearly 15 years." That statistic, he notes, is significant. "In all other instances, we have been able to resolve any potential disagreement at the Claims Committee level." He also says that although the Claims Committee's initial directive was to make decisions based solely

"What PMSLIC is trying to do is defend a doctor's right to a day in court, particularly when their medicine was right."

— Sarah H. Lawhorne, JD

on the acceptability of the medicine practiced, the review process has evolved into a much more sophisticated one which takes into account *all* aspects of each case.

"Doctors who serve on the PMSLIC Claims Committee have developed a keen sense of what constitutes negligence, whether there is causation, and what the likelihood is of winning at trial," according to Thistle. "Best of all is that in over 90 percent of the cases, the Claims Committee's decision to settle or defend is right on target with the ultimate disposition." Lawhorne says the Claims Committee process is one of the benefits of being a PMSLIC insured: "Medical professionals sit and talk about each case. That's just not done anywhere else. Giving physicians the opportunity to be reviewed by and to meet with peers to discuss their medicine in a non-hostile, non-confrontational environment is an immeasurable benefit."

An Innovative Project to Support Risk Management

PMSLIC is currently receiving national and international attention for its involvement in the Physicians Insurers Association of America (PIAA) data-sharing project. PIAA, organized in 1977, is a national association of 44 physician-owned or physician-directed medical professional liability insurance companies.

PIAA's data-sharing project was developed to provide member companies with current and credible statistics about medical malpractice claims to be used in risk-management programs. As data manager for the effort, PMSLIC is responsible for compiling and reporting information on the more than 83,000 claims received from 20 PIAA companies since 1985. Among the data collected is causation information; expense and indemnity payment amounts; claim severity; and demographic features pertaining to policyholders, claimants, and institutions.

Asked to explain the benefit of such information, Lori Bartholomew, PMSLIC's acting director of governmental relations and research, says, "Basically, the information is broken down by specialty group, so physicians can see what claims are causing problems for their specialty, at what expense, and which are costing the most money. Doctors can use the information as a guideline, especially in large-group practices, to see what claims they might expect to have indexed against them...It's a risk-management tool."

PMSLIC President Sarah H. Lawhorne feels the information is "very useful," providing statistical support for that which could only be assumed before. And Chairman of the Board Betty L. Cottle, MD, says the data "helps physicians develop an understanding of where they need to look at themselves critically...so they will know where the pitfalls are, where things are happening, where they need to pay attention, where they need to change their ways, where they need to beware."

The reports are updated semiannually and provided to the member companies participating in the project and to subscribers. The latest update, released in July and reporting information through December 31, 1991, "includes enhancements to make it easier to read and more useful for physicians," according to Bartholomew. Though outbranch reports on breast, colon, and lung cancer have been released in the past two years, only one full report has been available to date. For the future, however, Batholomew says PIAA is considering specialty-specific packets to make the information even more useful, accessible, and affordable for more people.

For additional information about the PIAA data-sharing project, call PMSLIC at 1-800-445-1212.

on call

Pennsylvania Medical Society

American Medical Association

The 1992 Member-Get-A-Member Program

The Champions of the Profession

Just as tall buildings are made a brick at a time, so strong organizations are built by individual members. Special thanks to each of these "builders" for the contribution each has made to the American Medical Association and to the profession we all serve. As physicians who answered our call to volunteer their time and their service to increase AMA membership, they are the champions of our profession.

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SEPTEMBER 1992

September 16, 1992
CRITICAL CARE MEDICINE: THE IMMUNOCOMPROMISED PATIENT
John M. Luce, M.D.
Associate Professor of Medicine and Anesthesia
University of California, San Francisco
Associate Director of Medical and Surgical ICU
San Francisco General Hospital, San Francisco, CA
Paul Lankin, M.D.
Associate Professor of Medicine
University of Pennsylvania School of Medicine
Director, Medical Intensive Care Unit
Hospital of the University of Pennsylvania,
Philadelphia, PA

September 23, 1992
RACIAL DIFFERENCES IN CORONARY ARTERY DISEASE AND HYPERTENSION
Charles K. Francis, M.D.
Professor of Clinical Medicine
Columbia University College of
Physicians and Surgeons
Chairman, Department of Medicine
Harlem Hospital Center, New York, NY

September 30, 1992
HEADLINE NEWS FOR THE INTERNIST: TOPICS THAT WILL INFLUENCE YOUR CAREER
David S. Kountz, M.D.
Assistant Professor of Medicine
Codirector, Medical Residency Program
Department of Medicine
Hahnemann University

OCTOBER 1992

October 7, 1992
Yom Kippur–No Grand Rounds

October 14, 1992
MECHANISMS OF GUT PEPTIDES IN NEUROENDOCRINE DISORDERS
Thomas O'Dorislo, M.D.
Professor of Medicine and Physiology
Director, Division of Endocrinology
Ohio State University, Columbus, Ohio

October 21, 1992
PULMONARY DISEASE
Jay N. Nadel, M.D.
Professor of Medicine and Physiology
Chief, Section of Pulmonary Diseases
Director, Multidisciplinary Training Program
in Lung Diseases, C.V.R.I.
University of California/San Francisco
San Francisco, CA

October 28, 1992
NEW APPROACHES TO IDENTIFICATION OF MYOCARDIAL ISCHEMIA
Leonard S. Dreifus, M.D.
Professor of Medicine
DIrector, Division of Cardiology
Hahnemann University
J. Yasha Kresh, Ph.D.
Professor and DIrector
Department of Cardiothoracic Surgery and
Professor of Medicine
Director of Cardiovascular Biophysics and Computing
Division of Cardiology
Hahnemann University
Amir Pelleg, Ph.D.
Associate Professor
Division of Cardiology
Hahnemann University

NOVEMBER 1992

November 4, 1992
HYPOTHYROIDISM: PATHOGENESIS AND IMMUNE MECHANISMS
E. Chester Ridgway, III, M.D.
Professor of Medicine
Head, Division of Endocrinology
University of Colorado Health Science Center
Denver, CO

November 11, 1992
CLINICAL REVIEW OF MORTALITY STUDIES IN CONGESTIVE HEART FAILURE
Gary S. Francis, M.D.
Professor of Medicine
Cardiovascular Division
University of Minnesota School of Medicine
Minneapolis, MN

November 18, 1992
MECHANISMS AND NEW STRATEGIES FOR TREATING AUTOIMMUNE DISEASES
David Wotsy, M.D.
Associate Professor of Medicine
Chief, Rheumatology Division
San Francisco VA Medical Center
San Francisco, CA

November 25, 1992
Thanksgiving Holidays – No Grand Rounds

DECEMBER 1992

December 2, 1992
ASTHMA BY INGESTION: ASPIRIN, SULFITE, M.S.G., & TARTRAZINE SENSITIVITY
Ronald Simon, M.D.
Associate Clinical Professor
of Medicine & Pediatrics
University of California/San Diego
School of Medicine
Head, Division of Allergy
& Clinical Immunology
Scripps Clinic and Research Foundation
La Jolla, CA

December 9, 1992
CHOLESTEROL REDUCTION IN PRIMARY PREVENTION: UNANSWERED QUESTIONS AND UNQUESTIONED ANSWERS
Jeremy Swan, M.D., Ph.D.
Professor of Medicine
UCLA School of Medicine
Los Angeles, CA

December 16, 1992
BREAST CANCER: DIAGNOSIS AND TREATMENT
Michael P. Moore, M.D., Ph.D.
Assistant Professor of Surgery
Cornell University School of Medicine
Sloan-Kattering Cancer Center
New York, NY

December 23, 1992
Christmas Holidays – No Ground Rounds

Hahnemann University Department of Medicine
Wednesday Medical Seminar Series
8:30 a.m.-3:30 p.m.

September 16, 1992
CRITICAL CARE OF THE IMMUNOSUPPRESSED PATIENT
Course Director: Harold L. Paz, M.D.
Guest Faculty: John M. Luce, M.D.
Paul Lankin, M.D.

October 21, 1992
PULMONARY MEDICINE
Course Director: Edward S. Schulman, M.D.
Guest Faculty: Jay A. Nadal, M.D.

November 18, 1992
MECHANISMS AND STRATEGIES FOR TREATING AUTOIMMUNE DISEASES
Course Director: Richard L. Spielvogel, M.D.
Guest Faculty: Alice Gottlieb, MD
Richard P. MacDermott, M.D.
David Wotsy, M.D.

December 2, 1992
ASTHMA
Course Director: David M. Lang, M.D.
Guest Faculty: Ronald Simon, M.D.

December 16, 1992
BREAST CANCER:
DIAGNOSIS AND TREATMENT
Course Codirectors: Jeffrey Brodsky, M.D.
Pamela Crilley, D.O.
Guest Faculty: Michael P. Moore, M.D., Ph.D.

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Allan B. Schwartz, M.D.
Professor and Vice Chairman of Medicine
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Understanding Durable Powers of Attoney

Susan M. Weber, Esq.

Many physicians will encounter the use of durable powers of attorney in their medical practices as patients become more informed and more prepared for end-of-life decisions. Be aware, however, that these documents vary in the authority they grant the holder, and that they differ significantly from living wills.

The Patient Self-Determination Act, a federal law which became effective December 1991, requires hospitals and other institutional health care providers to supply adult individuals with information concerning their rights under state law to accept or refuse medical treatment. Under that mandate, facilities must provide a description of state law with respect to advance directives. (For an in-depth discussion of the federal law, refer to "Implementation of Self-Determination Act Begins," PENNSYLVANIA MEDICINE, November 1991.) The class of "advance directives" includes living wills, durable powers of attorney for health care, and hybrid documents which include both.

Living wills were discussed in detail in the June 1992 issue of PENNSYLVANIA MEDICINE. This article will explain the durable power of attorney for health care and its implications for medical practice.

A power of attorney is a legal document in which a person (the "principal") nominates another individual to act in his or her stead and make decisions for him or her (the "attorney-in-fact"; for simplicity, shall be referred to as "agent"). The decisions of the agent are treated as if they had been made by the principal. The principal may confer a general power of attorney, but Pennsylvania statutes limit the agent's ability to make certain specific decisions by the powers granted in the document.

For example, if the instrument grants the powers to buy or sell stocks and to make financial gifts but not to create a trust, the agent may not create a trust, but may sell stocks if he or she deems it proper to do so. Similarly, if the power of attorney does not grant certain specific medical powers, the appointment of the agent is not effective as to medical decision-making.

The Pennsylvania statute sets forth the language that must be used in order to grant the agent the appropriate authority for medical decisions. That law permits the principal to authorize the agent to: admit the principal to hospitals, nursing homes, or similar residential facilities; enter into agreements for the care of the principal; arrange and contract for nursing care; and arrange for and consent to medical treatment, including surgery and the administration of drugs.

The statute does not explicitly permit the agent to refuse, reject, approve, or withhold treatment. Pennsylvania appellate courts have not yet addressed this issue. Some attorneys argue that implicit in the power to consent to treatment is the power to refuse or reject treatment. Others believe that since no case law has been reported which would lend credence to this position—and the legislature chose not to include the power to refuse or withdraw treatment in the statute—individuals may not grant that authority to agents. Suffice it to say that the legal community is divided, and the issue is still under debate.

A power of attorney will not survive the incapacity of the principal unless the document specifies that the principal intended its survival. Typically, the document will contain words similar to "this power of attorney shall not be affected by my subsequent disability or incapacity." The principal may indicate that the power will only become activated if he or she should become incapacitated by the use of a phrase similar to "this power of attorney shall become effective upon my incapacity." Without words showing that the powers are to extend beyond incapacity of the principal, the power of attorney is not considered "durable"; the agent, in reality, has no authority to render decisions after the principal's incapacity.

In a situation in which the agent who holds a non-durable power of attorney at-

"Some attorneys argue that implicit in the power to consent to treatment is the power to refuse or reject treatment."

Ms. Weber is assistant general counsel for the Pennsylvania Medical Society.

tempts to make health care decisions for an incapacitated patient, the physician involved should consult an attorney. It may in fact be appropriate for this person to make necessary decisions. For example, the person who holds the power of attorney may also be the patient's next of kin, who would normally make decisions in the absence of a legal document granting that authority to another person.

Complicating the issue, Act 24 of 1992, in addition to enacting Pennsylvania's living will law, amended the state's guardianship statute. Under previous law, when a person was found by a court to be "incompetent," a guardian was appointed who would make all decisions for the incompetent person. The amendments, however, provide for varying levels of "incapacity" and require participation of the incapacitated person to the maximum extent possible in all decisions in which he or she is able to participate.

Thus, a person may be incapacitated for some purposes and not others. A court may appoint a guardian to handle the incapacitated person's finances, but not his or her health care decisions. Even when a guardian has been appointed for health care, the guardian must encourage participation in decisions to the extent the incapacitated person is able.

Durable power of attorney vs. living will

While both are considered types of advance directives, a durable power of attorney differs from and is not interchangeable with a living will.

A living will is used to inform health care providers about the medical treatment which the individual desires or wishes to avoid at the end of life. It is applicable only in narrowly drawn circumstances, generally when a person becomes incompetent and either terminally ill or permanently unconscious. A living will may also be utilized to appoint a proxy or surrogate decision maker, but the proxy may only make medical decisions and may make them only after the living will has become operative, that is, after a physician determines that the patient is incompetent and either terminally ill or permanently unconscious.

A durable power of attorney, by contrast, merely appoints an agent to make decisions for the principal and can be activated whenever a person becomes incapacitated. For example, an agent may make decisions during the time the principal is under anesthesia if any medical decisions arise. Of course, the power of attorney must first grant medical decision-making authority to the agent. And unlike the living will, the durable power of attorney does not offer any guidance to the agent with respect to the decisions he or she is expected to make.

Legislative update

The Pennsylvania Bar Association (PBA) has approved and will be seeking amendments to Pennsylvania's Power of Attorney Statute which would specifically relate to health care powers of attorney. Proposed amendments address such issues as:

- The scope of power that can be granted to an agent.
- How and by whom is a principal's incapacity to make medical decisions determined.
- Criteria an agent should use in making a health care decision.
- How health care powers of attorney are revoked.
- Whether a physician or health care provider can, on grounds of conscience, refuse to follow instructions that are contained in a health care power of attorney or given to an agent.

PBA intends to introduce these and other health care durable power of attorney amendments to the Senate this fall.

"Physicians, be aware"

As patients become more knowledgeable about their choices in health care decisions, and they choose to use durable powers of attorney more frequently in the coming years, physicians need to be aware that not all powers of attorney are equal. Routinely inspect powers of attorney with which you are presented, for language granting medical decision-making powers as well as that which makes the powers "durable" beyond a patient's incapacity.

"...physicians need to be aware that not all powers of attorney are equal."

PAMPAC SURVEYS LEGISLATIVE CANDIDATES

In June, the Pennsylvania Medical Political Action Committee (PaMPAC), with the technical assistance of The Educational and Scientific Trust of the Pennsylvania Medical Society, conducted a survey of federal and state legislative candidates on their views on medical issues. The survey was conducted under the guidelines of a resolution adopted by the Society's House of Delegates in 1990. This is the first survey of candidates' opinions for the Pennsylvania Medical Society.

Federal candidates and state candidates received separate surveys. Each questionnaire listed eight policy statements. For each statement, the candidate was asked to mark a response of Strongly Agree, Agree, Disagree, Strongly Disagree, or No Opinion. Those candidates who did not respond by June 30, 1992, received a second survey. The specific policy statements and the views of the 250 respondents are printed on the following pages.

There were several candidates who courteously responded by indicating that it is their personal policy not to respond to these types of surveys. Most cited the large number of surveys which they receive. Those individuals are:

Federal:
Bill Clinger - 5th District
Curt Weldon - 7th District

State Senate:
Vincent J. Fumo - 1st District
Richard A. Tilghman - 17th District

State House:
Ron Brandon - 11th District
David J. Mayernik - 29th District
Lynn B. Herman - 77th District
Richard A. Geist - 79th District
Patricia H. Vance - 87th District
Ellen A. Harley - 149th District
Joseph R. Pitts - 158th District
Nicholas A. Micozzie - 163rd District
William W. Rieger - 179th District

If a candidate did not return a survey, there is no listing under the appropriate legislative district.

PaMPAC also received three questionnaires without names to identify the candidate.

Interviews with U.S. senatorial candidates Arlen Specter and Lynn Yeakel had been planned for the summer. Interview highlights are scheduled to be published in the October issue of PENNSYLVANIA MEDICINE.

FAST FACTS:
1992 General Election

Federal - President*
Vice President*
1 U.S. Senator*
21 U.S. Representatives

State - 25 State Senators
203 State Representatives
Attorney General*
Auditor General*
Treasurer*

Last Day to Register to Vote with County Election Bureaus - October 5, 1992.

** Surveys not applicable for these elected offices.*

Federal Legislative Candidates

KEY

SA - Strongly Agree **A** - Agree **SD** - Strongly Disagree **D** - Disagree **NO** - No Opinion **NR** - No Response

Federal District	Candidate * Indicates Incumbent	1. Pennsylvania physicians should be granted an exemption from the federal Clinical Laboratory Improvement Act, 1988, because Pennsylvania regulations are as stringent as federal regulations.	2. The new RBRVS Medicare physician payment system should be fully implemented without further Medicare payment restrictions.	3. Medicare reimbursement mechanisms should not be expanded into the private sector.	4. The Medicare Physician Regulatory Relief Amendments of 1991 (H.R. 2695, S. 1332) should be adopted as they would greatly reduce the administrative burden of the practice of medicine.	5. As the state's Medicare carrier, Pennsylvania Blue Shield should be required to reevaluate in-state locality designations as part of Medicare payment reform.	6. Separate physician reimbursement for the professional component of EKG analysis should be restored.	7. Medical liability reform could be a prominent factor in containing health care costs.	8. Physicians should be allowed to test patients for HIV, maintaining their privacy but without explicit consent, when a health care worker has been placed at risk by exposure to body fluids.
1st District	Craig Snyder (R)	D	A	A	A	NO	D	A	A
2nd District	Larry Hollin (R)	A	NR	SA	A	A	NO	SA	SA
3rd District	Charles F. Dougherty (R)	A	NO	A	A	A	NO	SA	A
4th District	Gordon R. Johnston (R)	NO	NO	A	SA	NO	A	SA	SA
6th District	John E. Jones (R)	A	A	SA	A	NO	SA	SA	SA
7th District	Frank Daly (D)	D	D	D	SA	SA	NO	A	A
8th District	*Peter H. Kostmayer (D)	D	A	NO	SA	NO	SA	A	SD
13th District	Jon D. Fox (R)	A	A	NO	A	A	A	SA	A
14th District	Byron W. King (R)	SA	SA	SA	SA	SA	SA	SA	SA
15th District	*Don Ritter (R)	SA	A	SA	A	NO	SA	SA	SA
16th District	Robert Peters (D)	SA	NO	D	NO	SA	A	D	A
19th District	Paul V. Kilker (D)	A	A	SA	SA	A	SA	A	A
20th District	Bill Townsend (R)	D	A	SA	NO	SA	SA	SA	D
	*Austin J. Murphy (D)	SA	SA	NR	SA	A	A	SA	A

KEY

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State Senate Candidates

State Senate District	Candidate * Indicates Incumbent	1. Medical liability reform could be a prominent factor in containing health care costs.	2. The Certificate of Need process should be abandoned and the health care community should be permitted to operate as a free market.	3. The Health Care Cost Containment Council is unable to appropriately measure quality of care.	4. Linking any third party reimbursement other than care of the elderly to Medicare rates is inappropriate and unfair to physicians.	5. Reimbursing physicians for workers' compensation claims at a rate permanently tied to Medicare rates will eventually lead to a reduction in access to appropriate health care for injured workers.	6. Physicians should have the right to conduct HIV testing at their discretion, without obtaining a patient's consent.	7. A physician's decision to treat or not treat indigent patients should in no way be linked to licensure.	8. A thorough legislative review should occur before any professional health care group's licensed scope of care is expanded.
1st District	Karl H. DeSimone (R)	SA	SD	D	D	NO	SD	SD	SA
3rd District	Michael G. Floyd (R)	SA	D	SA	SA	SA	SA	SA	SA
5th District	*Frank Salvatore (R)	SA	A	SA	SA	SA	NO	A	SA
9th District	*Clarence D. Bell (R)	SA	NO	SA	SA	SA	A	SA	SA
	Mary Ellen McLaughlin (D)	SA	SD	SD	SA	A	SA	A	SA
11th District	Joyce O'Brien (R)	A	A	A	A	A	D	A	SA
	*Michael A. O'Pake (D)	A	A	A	A	A	A	A	A
13th District	Joanne A. Petitto (D)	A	D	NO	D	D	A	A	D
15th District	Dave Tamanini (D)	A	D	A	D	D	D	A	A
21st District	Rich Bartchy (D)	A	D	D	A	A	SD	A	A
23rd District	Harry A. VanSickle (D)	A	D	A	D	A	NR	D	A
25th District	*John E. Peterson (R)	SA	D	D	SA	SA	D	A	A
	Howard Shakespeare (D)	SA	D	A	NO	D	D	A	A
27th District	*Edward W. Helfrick (R)	SA	NR	NO	SA	SA	SA	D	NO
31st District	Hal Mowery (R)	A	A	A	A	A	A	A	A
	Robert H. Fowler (D)	A	NO	NO	D	NO	SA	SA	A
33rd District	*Terry Punt (R)	SA	SA	A	A	SA	A	A	SA
35th District	Tony Joseph (R)	SA	SA	NO	NO	SA	SA	SA	SA
	*William J. Stewart (D)	SA	D	A	A	A	A	A	SA
37th District	*D. Michael Fisher (R)	SA	A	A	A	SA	A	SA	SA
39th District	Mike Smith (R)	SA	NO	NO	A	A	SA	A	SA
	*Gene Porterfield (D)	NO	A	D	A	A	D	A	NO
41st District	Lance Alexander (R)	SA	SA	SA	SA	SA	SA	SA	SA
	*Patrick J. Stapleton (D)	SA	D	D	SA	A	SA	SA	SA
43rd District	*Michael M. Dawida (D)	SA	NO	A	A	A	NO	A	A
49th District	Steven M. Brooder (R)	A	SA	SA	A	A	A	A	A

State Representative Candidates

State House District	Candidate * Indicates Incumbent								
1st District	Jerry E. Knight (R)	SA	A	A	NO	D	NO	D	SA
	Linda Bebko Jones (D)	SA	D	D	D	D	A	D	A
2nd District	Jay Shimek (R)	SA	NO	A	D	A	D	SA	A
3rd District	*Karl W. Boyes (R)	SA	A	A	A	A	SA	SA	SA
4th District	Eric M. Marshall (R)	SA	SA	A	SA	SA	D	SA	A
	*Tom Scrimenti (D)	SA	NO	A	A	A	D	A	A
5th District	*James R. Merry (R)	SA	NO	A	A	A	A	A	A
6th District	*Teresa E. Brown (R)	A	A	A	A	A	NR	A	A
	Virginia F. Wade (D)	A	A	NR	A	NR	D	A	A

State Representative Candidates (cont.)

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NR - No Response

State House District	Candidate * Indicates Incumbent	1. Medical liability reform could be a prominent factor in containing health care costs.	2. The Certificate of Need process should be abandoned and the health care community should be permitted to operate as a free market.	3. The Health Care Cost Containment Council is unable to appropriately measure quality of care.	4. Linking any third party reimbursement other than care of the elderly to Medicare rates is inappropriate and unfair to physicians.	5. Reimbursing physicians for workers' compensation claims at a rate permanently tied to Medicare rates will eventually lead to a reduction in access to appropriate health care for injured workers.	6. Physicians should have the right to conduct HIV testing at their discretion, without obtaining a patient's consent.	7. A physician's decision to treat or not treat indigent patients should in no way be linked to licensure.	8. A thorough legislative review should occur before any professional health care group's licensed scope of care is expanded.
8th District	*Howard L. Fargo (R)	SA	A	A	A	A	A	SA	A
9th District	Frank J. Harvan (R)	A	D	A	D	D	A	SD	A
	*Thomas J. Fee (D)	A	A	A	A	A	A	A	A
10th District	*Frank LaGrotta (D)	SA	NO	A	A	A	NO	A	D
11th District	*Joseph A. Steighner (D)	SA	D	NO	D	D	NO	NO	SA
12th District	*Pat Carone (D)	A	D	D	NO	NO	SD	SA	SA
13th District	*Arthur D. Hershey (R)	A	NO	NO	A	D	SA	A	SA
14th District	Richard D. Dinello (R)	SA	NO	SA	A	A	SA	SA	SA
15th District	Dale S. Laughner (R)	SA	NR	NR	A	A	A	A	SA
	*Nicholas A. Colafella (D)	SA	SA	D	A	A	A	A	D
16th District	Pete Schlicht (R)	A	A	A	NR	NR	NR	NR	NR
17th District	*David O. King, DDS (R)	SA	SA	SA	SA	SA	A	SA	SA
	Jon S. Servidio (D)	A	A	NO	A	A	SD	A	A
19th District	Charles Hawkins (R)	SA	SA	SA	SA	SA	SA	SA	SA
	*William R. Robinson (D)	SA	D	A	A	SA	SA	D	SA
20th District	Marc E. O'Neill (R)	SA	D	A	A	D	SA	A	SA
	*Thomas J. Murphy (D)	SA	SD	A	D	A	D	SD	SA
23rd District	*Ivan Itkin (D)	A	D	D	D	D	D	SA	SA
24th District	*Joseph Preston, Jr. (D)	A	SD	NO	SA	A	D	A	SA
26th District	Harry O. McMullen (D)	SA	SA	NO	A	A	A	A	NO
27th District	John R. Serpa (R)	A	NR	NR	NR	NR	SA	NR	D
	Thomas C. Petrone (D)	SA	A	SA	A	A	SA	SA	A
28th District	*Elaine F. Farmer (R)	SA	A	NO	A	A	A	SA	D
	Larry Brudy (D)	D	SA	A	A	A	SD	D	SA
31st District	David J. Steil (R)	SA	D	D	A	D	A	D	A
32nd District	*Anthony M. DeLuca (D)	SA	D	D	A	NR	D	A	D
34th District	*Ronald R. Cowell (D)	SA	D	A	SA	A	SA	SA	SA
35th District	*Tom Michlovic (D)	A	D	SD	D	SD	SD	A	A
36th District	Bob Huemmrich (R)	SA	SA	NO	NO	NO	SD	SA	NO
	*Chris McNally (D)	SD	D	D	D	D	D	D	SA
37th District	Katie True (R)	SA	D	SA	A	NO	A	A	SA
38th District	Richard L. Renner (R)	A	NR	A	NR	NR	A	NR	NR
39th District	John L. Patterson (R)	SA	SA	SA	SA	SA	SA	SA	SA
40th District	Albert W. Pettit (R)	SA	A	A	SA	SA	SA	A	SA
41st District	Allan C. Kirschman (R)	SA	SA	SA	SA	A	SD	D	SA
42nd District	*Greg Fajt (D)	A	NO	D	A	A	SD	A	SA
43rd District	*Jere W. Schuler (R)	SA	NR	NO	A	SA	SA	SA	SA
44th District	Douglas Lee Martin (R)	NR	NR	NR	NR	NR	A	D	A

State Representative Candidates (cont.)

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State House District	Candidate * Indicates Incumbent	1. Medical Liability Reform	2. Certificate of Need	3. Health Care Cost Containment Council	4. Third Party Reimburse-ment	5. Workers' Compensation Reimburse-ment	6. Physician Discretion/HIV Testing	7. Treatment of the Indigent/ Licensure	8. Expansion of Licensed Scope of Care
45th District	David J. Peart (R)	SA	A	A	A	A	D	NO	NO
	*Fred A. Trello (D)	SA	A	A	NO	A	A	A	A
46th District	*Victor John Lescovitz (D)	SA	A	A	A	A	A	A	A
47th District	*Leo J. Trich, Jr. (D)	SA	A	A	A	A	A	D	A
49th District	*Peter J. Daley (D)	D	D	D	A	D	SA	A	A
50th District	*H. William DeWeese (D)	A	D	D	D	D	D	NO	A
51st District	Gloria Saloom (R)	SA	A	SA	SA	A	A	SA	D
	Larry Roberts (D)	A	SA	A	NO	NO	SA	NO	SA
52nd District	Harry Young Cochran (R)	SA	A	SA	SA	SA	A	SA	SD
	*Richard A. Kasunic (D)	A	A	NO	D	D	D	A	A
53rd District	*Robert W. Godshall (R)	SA	NO	D	A	A	NO	SA	NO
54th District	Hilary Holste (R)	A	A	NO	D	D	A	A	A
	*Terry E. Van Horne (D)	A	NO	D	NO	A	D	SA	D
55th District	Robert H. Long (R)	A	A	A	A	A	A	A	A
56th District	David C. Anderson (R)	SA	A	A	A	NO	A	NO	SD
57th District	James M. Hutchison (R)	SA	A	A	A	A	SA	D	NR
	*Thomas A. Tangretti (D)	SA	D	D	A	A	A	SA	SA
59th District	*Jess Stairs (R)	SA	A	A	A	A	SA	SA	A
60th District	Keith Hansen (R)	A	A	D	A	D	D	A	A
	*Timothy L. Pesci (D)	NO	SD	SD	NO	NO	A	D	A
61st District	*Joseph M. Gladeck, Jr. (R)	SA	SA	SA	SA	SA	NO	SA	SA
63rd District	Fred C. McIlhattan (R)	SA	D	D	SA	SA	D	A	A
	*David R. Wright (D)	SA	A	A	D	D	A	SA	A
64th District	Scott E. Hutchinson (R)	SA	A	SA	D	D	A	A	A
	Edith L. Sally Abate (D)	A	D	D	D	D	D	SD	D
65th District	*Curtis S. Bowley (D)	A	D	D	D	D	NO	NO	A
66th District	*Sam Smith (R)	SA	NO	D	A	A	A	A	A
68th District	Matthew E. Baker (R)	SA	A	A	A	A	A	A	A
69th District	Carl C. Lincoln, Jr. (R)	SA	SA	SA	SA	A	SA	A	SA
	*William R. Lloyd, Jr. (D)	A	SD	A	D	D	A	A	SA
70th District	Jeff Zolitor (D)	SA	NO	NO	NO	NO	NO	SA	NO
71st District	*Leona Lee Telek (R)	A	A	D	A	NO	SA	A	A
	*John N. Wozniak (D)	SA	D	A	NO	D	A	A	A
72nd District	Robert E. Barrett (R)	SA	A	A	SD	SA	SA	SA	SA
73rd District	Vince Golden (R)	SA	SD	SA	A	A	NO	D	SA
	*Edward J. Haluska (D)	A	NO	NO	NO	NO	SA	A	A
74th District	*Camille George (D)	SA	A	SA	A	A	A	A	A
75th District	Jim Distler (R)	SA	A	A	A	A	SA	SA	A
76th District	Nathan Walizer (R)	SA	SA	NO	A	A	SA	SA	NO
	*Mike Hanna (D)	SA	NO	NO	D	D	A	A	D
77th District	Mike Radis (D)	A	NO	NO	A	A	SD	D	A
80th District	Jerry Stern (R)	SA	SA	SA	SA	A	SA	SA	SD
	Joseph Wiedemer (D)	SA	A	A	A	D	SA	SA	D
81st District	Larry O. Sather (R)	A	D	A	A	A	D	A	NO
	John P. Mills (D)	SA	A	NO	A	A	SA	A	A
82nd District	*Daniel F. Clark (R)	SA	NO	A	A	A	A	SA	SA
	Phyllis Harmon (D)	SA	SA	A	A	A	SA	A	A
83rd District	*Thomas W. Dempsey (R)	SA	SA	A	SA	SA	SA	SA	SA
84th District	*Alvin C. Bush (R)	SA	NR	A	A	A	A	A	A
85th District	*Russell Fairchild (R)	SA	A	A	A	SA	SA	SA	SA

State Representative Candidates (cont.)

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State House District	Candidate * Indicates Incumbent	1. Medical liability reform could be a prominent factor in containing health care costs.	2. The Certificate of Need process should be abandoned and the health care community should be permitted to operate as a free market.	3. The Health Care Cost Containment Council is unable to appropriately measure quality of care.	4. Linking any third party reimbursement other than care of the elderly to Medicare rates is inappropriate and unfair to physicians.	5. Reimbursing physicians for workers' compensation claims at a rate permanently tied to Medicare rates will eventually lead to a reduction in access to appropriate health care for injured workers.	6. Physicians should have the right to conduct HIV testing at their discretion, without obtaining a patient's consent.	7. A physician's decision to treat or not treat indigent patients should in no way be linked to licensure.	8. A thorough legislative review should occur before any professional health care group's licensed scope of care is expanded.
86th District	C. Allan Egolf (R)	SA	D	NO	A	A	A	A	NO
	Sandra M. Philpott (D)	NO	D	NO	A	A	A	A	D
88th District	*Jerry L. Nailor (R)	A	NO	D	NO	NO	A	A	A
89th District	*Jeffrey W. Coy (D)	SA	A	A	A	NO	A	A	A
90th District	*Patrick E. Fleagle (R)	SA	D	D	SA	A	SA	SA	SA
91st District	Stephen R. Maitland (R)	SA	D	NO	SA	NO	SD	A	A
	*Kenneth J. Cole (D)	SA	NO	A	A	SA	A	A	D
92nd District	*Bruce Smith (R)	SA	D	A	A	A	D	A	A
	John S. Brenner (D)	A	D	D	D	D	D	D	D
93rd District	Michael L. Waugh (R)	A	NO	NO	D	D	D	A	A
	Al Smith (D)	SA	A	A	SA	SA	SA	SA	SA
94th District	Douglas E. Kilgore (D)	SA	NO	NO	NO	NO	D	A	A
95th District	*Stephen H. Stetler (D)	A	D	D	D	D	D	A	A
96th District	Steven J. Geisenberger (R)	A	NO	A	A	D	A	A	SA
	*P. Michael Sturla (D)	A	D	A	A	A	D	A	SA
97th District	*Jere L. Strittmatter (R)	A	SA	NR	NR	NR	NR	A	A
	Bruce W. Debord (D)	A	A	NO	A	A	NO	A	A
98th District	*Thomas E. Armstrong (R)	SA	A	NO	A	NO	SA	A	A
100th District	*John E. Barley (R)	A	A	A	A	A	SA	SA	A
101st District	Rose Marie Swanger (R)	SA	A	NO	SA	SA	SA	SA	NO
102nd District	Peter J. Zug (R)	A	SA	A	SA	SA	A	SA	SA
104th District	*Jeffrey E. Piccola (R)	A	A	NO	A	A	NO	NO	NO
	D. Randy Long (D)	A	NO	D	A	D	A	NR	A
105th District	*Ron Marsico (R)	A	A	D	A	A	A	A	SA
	Susan Leighow (D)	A	D	A	NO	A	A	A	A
106th District	*Frank Tulli, Jr. (R)	SA	NO	D	A	A	A	A	A
107th District	*Robert E. Belfanti, Jr. (D)	A	D	A	A	A	A	A	A
109th District	Randy A. Peters (R)	SA	A	SA	A	A	D	SA	A
	John R. Gordner (D)	A	D	NO	NO	D	D	A	A
110th District	*J. Scot Chadwick (R)	SA	SA	D	SA	SA	SA	SA	SA
111th District	*Kenneth E. Lee (R)	SA	A	D	A	A	D	A	D
	Ron Williams (D)	SA	NO	A	SA	SA	SA	A	SA
114th District	Tom Philbin (D)	A	A	A	A	A	D	A	A
115th District	*Edward G. Staback (D)	A	NR	D	NR	A	SA	SA	A
116th District	James Skip Ford (R)	SA	D	A	A	A	SA	A	A
	*Thomas B. Stish (D)	SA	A	A	A	NO	NR	A	A
118th District	*Thomas M. Tigue (D)	A	A	D	D	D	A	A	SA
119th District	*Stanley J. Jarolin (D)	SA	A	A	SA	SA	A	SA	SA
120th District	*Phyllis Mundy (D)	A	NO	NO	A	A	D	A	A
123rd District	Ted Koval (R)	SA	A	A	NO	NO	SA	A	SA
124th District	*David G. Argall (R)	SA	A	A	NO	NO	A	A	SA

State Representative Candidates (cont.)

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125th District	*Bob Allen (R)	SA	A	A	SA	SA	A	A	SA
126th District	Dante Santoni, Jr. (D)	A	D	NO	D	D	D	A	A
127th District	*Thomas R. Caltagirone (D)	A	D	SD	D	D	A	A	A
128th District	Sam Rohrer (R)	SA	SA	A	A	A	A	A	D
	David T. Gatz (D)	A	NO	NO	A	A	D	NO	NO
129th District	Sheila Miller (R)	A	A	A	A	A	D	A	A
	Judith Kraines (D)	SA	NO	SA	SA	A	A	SA	SA
130th District	*Dennis E. Leh (R)	SA	SA	NO	A	A	SA	SA	NO
131st District	*Karen A. Ritter (D)	SA	SA	SD	A	A	SD	A	SA
133rd District	T. J. Rooney (D)	SA	D	NO	A	A	D	A	A
134th District	*Don Snyder (R)	SA	SA	SA	SA	SA	NO	SA	SA
	Ellie Kirby (D)	A	A	NO	A	SA	SA	A	A
135th District	*Joseph M. Uliana (R)	A	SA	SA	A	A	SA	A	SA
	James S. Gregory (D)	SA	NO	A	NO	A	SA	SA	A
136th District	*Robert Freeman (D)	D	D	D	D	D	D	D	A
137th District	*Leonard Q. Gruppo (R)	A	A	A	A	A	A	A	A
	Larry Spinato (D)	SA	D	SA	SA	SA	A	D	A
138th District	*Bob Nyce (R)	A	A	A	A	A	NO	A	A
139th District	*Jerry Birmelin (R)	SA	A	D	A	A	NO	SA	A
140th District	William J. Mullen (R)	A	A	A	A	A	SD	D	D
	*Thomas C. Corrigan, Sr. (D)	SA	SA	SA	A	A	SA	A	A
141st District	*Anthony J. Melio (D)	SA	A	A	A	A	SD	A	A
142nd District	*Matthew N. Wright (R)	SA	A	A	A	A	SA	A	SA
	Karen Ann Selvaggi (D)	A	A	A	SA	SA	NO	A	A
143rd District	*David W. Heckler (R)	SA	D	A	SA	SA	A	SA	SA
144th District	Tom Druce (R)	A	NO	A	A	A	A	A	A
145th District	*Paul I. Clymer (R)	SA	A	A	A	NO	A	SA	A
146th District	*Robert D. Reber, Jr. (R)	A	D	D	D	A	A	D	A
147th District	*Raymond Bunt, Jr. (R)	SA	SA	SA	SA	SA	SA	SA	SA
	Keith A. Strunk (D)	SA	SD	A	SA	SA	SD	D	D
148th District	Lita Indzel Cohen (R)	A	A	A	A	A	D	A	A
	Eric Bradway (D)	SA	SA	SA	SA	SA	SA	SA	SA
149th District	Felice G. Wiener (D)	SA	D	A	D	D	SD	A	A
150th District	*John A. Lawless (R)	SA	A	SA	A	A	SA	A	A
151st District	*George E. Saurman (R)	SA	A	NO	SA	SA	A	SA	NO
153rd District	David Barol (D)	SA	D	D	D	A	D	A	A
154th District	Thomas Jay Ellis (R)	SA	SA	A	A	A	SD	A	A
	Lawrence H. Curry (D)	SA	D	A	D	D	A	A	SA
156th District	*Elinor Z. Taylor (R)	SA	A	D	SA	SA	A	A	SA
157th District	Carole A. Rubley (R)	A	D	NO	NO	NO	A	A	A
158th District	Millie Gobe (D)	A	NO	A	A	A	NO	NO	A
160th District	*Kathrynann W. Durham (R)	A	SA	SA	A	A	A	A	A
161st District	Thomas J. Elverson (D)	A	SD	NO	A	D	A	A	A
162nd District	*Ronald Raymond (R)	A	NO	D	NO	A	A	A	A
	Joanna Christaldi (D)	SA	A	A	A	A	NR	A	A
163rd District	Eugene E. DeLuca (D)	A	SD	SA	SD	A	D	D	SD
164th District	*Mario J. Civera, Jr. (R)	A	A	A	A	SA	SA	D	SA
	Catherine Mary McAllister (D)	A	SA	NO	SA	SA	NO	SA	SA

State Representative Candidates (cont.)

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NO - No Opinion
NR - No Response

State House District	Candidate * Indicates Incumbent	1. Medical liability reform could be a prominent factor in containing health care costs.	2. The Certificate of Need process should be abandoned and the health care community should be permitted to operate as a free market.	3. The Health Care Cost Containment Council is unable to appropriately measure quality of care.	4. Linking any third party reimbursement other than care of the elderly to Medicare rates is inappropriate and unfair to physicians.	5. Reimbursing physicians for workers' compensation claims at a rate permanently tied to Medicare rates will eventually lead to a reduction in access to appropriate health care for injured workers.	6. Physicians should have the right to conduct HIV testing at their discretion, without obtaining a patient's consent.	7. A physician's decision to treat or not treat indigent patients should in no way be linked to licensure.	8. A thorough legislative review should occur before any professional health care group's licensed scope of care is expanded.
165th District	Robert M. Hartman (D)	SA	D	NO	NO	NO	SA	NO	A
166th District	Joan Farrell Genthert (R)	SA	NO	A	A	A	A	A	A
170th District	*George T. Kenney, Jr. (R)	A	D	D	A	A	A	A	A
	Nancy Woods (D)	SA	SA	SA	SA	SA	SA	SA	SA
171st District	Mark Milliron (R)	A	A	A	D	D	SA	SA	SA
	*Ruth C. Rudy (D)	A	A	SA	A	A	SA	A	SA
172nd District	*John M. Perzel (R)	SA	A	A	A	SA	SA	SA	SA
176th District	*Chris Wogan (R)	A	NO	NO	A	A	A	SA	NO
	Anne M. Rubin (D)	SA	D	A	A	A	SD	A	SA
179th District	Joseph F. MacFarland (R)	A	NO	NO	A	D	A	A	A
182nd District	*Babette Josephs (D)	A	D	D	D	D	SD	A	A
183rd District	Charles O. Gross (R)	SA	NR	NO	A	SA	A	A	NO
	Frank W. Yandrisevits (D)	A	D	A	D	D	A	A	A
185th District	Guy Ciarrocchi (R)	SA	A	A	SA	SA	D	A	SA
186th District	*Harold James (D)	A	D	D	A	NO	A	NO	A
189th District	Carl J. Link (R)	SA	NO	A	D	D	SA	A	NO
	*Joseph W. Battisto (D)	A	D	D	NR	D	A	A	A
192nd District	*Louise Bishop (D)	SA	NO	A	A	A	SD	A	A
193rd District	*Steven R. Nickol (R)	A	NO	A	A	A	A	A	A
195th District	*Frank L. Oliver (D)	SA	SD	SD	A	SA	A	A	A
197th District	Michael Duncan (R)	A	D	A	A	SD	A	A	D
	*Andrew J. Carn (D)	NO	NO	NO	NO	NO	D	NO	A
199th District	Al Masland (R)	SA	A	A	A	A	A	A	A
	Grace L. Jarvis (D)	SA	NO	SA	A	SA	D	D	SA

ON THE LEGISLATIVE CALENDAR THIS FALL

Several medical issues are likely to appear on the legislative calendar when the Senate and House reconvene on September 21 in Harrisburg. Among the most important issues affecting medicine are workers' compensation; indigent care; supplemental funding for private medical schools; and the generic drug reimbursement policy of PACE, the lottery's prescription drug program.

The following is an update of the issues and the Society's position on each.

Workers' compensation

Legislation revising the Commonwealth's workers' compensation law was again amended by the Senate and is now pending before the House. The Senate, in a rare procedural move, chose not to insist on previous Senate amendments to House Bill 2140 (Workers' Compensation Act).

The new amendments, offered by Senators Roger A. Madigan (R-Bradford) and Robert J. Mellow (D-Lackawanna), varied from the previously passed version in the following areas:

- removal of language stipulating ownership of coordinated care organizations (CCOs);
- sunset of the fraud provisions on January 31, 1995;
- clarification of language denying a 52 percent rate increase request and the file-and-use system for rate filings; and
- request of prior approval of future lost cost filings.

During discussions which led to the revised Madigan/Mellow amendments, there was a significant attempt to further limit medical costs, but Senators Madigan and Mellow said they could not support additional cuts and refused to consider further changes. Thus, the basic medical language was untouched. As it stands now, the bill would:

- provide for reimbursement for the remainder of 1992 for health care providers the lesser of 120 percent of the appropriate Medicare payment or the provider's usual customary and reasonable fee, or 80 percent of the usual customary and reasonable fee of like providers where no Medicare allowance exists;
- provide that on January 1, 1993, and annually thereafter, allowances would be updated by the percentage change in statewide average weekly wage;
- permit employers or insurers to negotiate different fees with certain providers;
- require the labor secretary to hire a consultant to perform an annual accessibility study of medical care under workers' compensation;
- require payment allowance to be reviewed when it is more than 10 percent less than the average payment by a coordinated care organization;
- permit formation of coordinated care organizations (CCOs), and allow one or more CCOs to be included on the list of providers posted by an employer;
- lock an employee in for up to 45 days of initial visit to one of the listed providers;
- provide exemption from Medicare limits for trauma and burn services performed in designated facilities; and
- provide for use of utilization review organizations for review of reasonableness or necessity of services with employer paying the cost of initial review and the party requesting reconsideration paying, subject to reimbursement if successful.

If the House considers House Bill 2140 when they return, the Society will call for a vote to concur with the Senate amendments, thus approving the bill in its current form (Printer's Number 3913). While the Society dislikes the tie to Medicare, it is only temporary under the current language.

Any major revisions could lead to further attempts to remove the allowance update which, in the long run, would be less beneficial for physicians and their patients. In the meantime, the Society will continue to pursue other initiatives to achieve improvements to the workers' compensation system.

Indigent care

As House Bill 20, introduced by Representative Allen G. Kukovich (D-Westmoreland), passed the House in December, the Society worked successfully to remove language tying licensure and medical staff privileges to mandated Medicaid participation. The Society then offered an amendment to revise remaining language of concern and participated in meetings called by Senator John E. Peterson (R-Venango) to revise the bill before it was considered.

House Bill 20 is now in the Senate Appropriations Committee, and the language requested by the State Society has been amended into the bill. A conference committee is likely to resolve differences between the House and Senate versions of the bill if new language proposed by Democratic legislators is not acceptable.

Supplemental funding for private medical schools

The vehicle for this year's General Appropriation Budget Act, House Bill 1320, was signed by the governor on June 30, at which time he "line-item vetoed" 45 items. Among those items maintained was the governor's 3.5 percent cut for medical schools at Pittsburgh, Penn State, and Temple. However, the legislature rejected an additional 3.5 percent cut in current funds.

At this time, legislation providing funds for private institutions, including medical schools, has not been passed for the 1992-93 fiscal year. The Society supports supplemental funding and will continue to work for such legislation.

Generic drug reimbursement policy

House Bill 2442 originally required that senior citizens participating in the PACE program automatically be given generic drugs, when suitable. As approved by a vote of 187-8 in the House, the bill now includes language permitting payment for non-generic drugs when the patient has an allergic reaction.

The Senate also approved new language allowing physicians to prescribe brand-name drugs by writing "brand necessary" or "brand medically necessary" on the prescription. The Senate, prior to June recess, passed the bill 45-3. Supported by the Society, the bill now faces a concurrence vote in the House on the Senate amendments.

The Society will continue to update members on movement of these issues and others after the legislature convenes this month.

Donald N. McCoy, the Society's director of regulatory affairs and specialty legislation, contributed to this page.

HCFA TAKES ON "HASSLE FACTOR"

The Health Care Financing Administration (HCFA) has released an advisory report making recommendations to reduce administrative burdens on physicians. The report, published by an advisory panel on Medicare-physician relationships, addressed the administrative "hassles" that physicians deal with in working with the Medicare program.

The panel included HCFA's senior medical advisor, Nancy E. Gary, MD, and seven practicing physicians from various disciplines. Secretary of Health and Human Services Louis W. Sullivan, MD, formed the panel in 1991 in response to complaints by providers that Medicare's administrative workload had become too great, adding unduly to office overhead costs and interfering with the relationship between physicians and their patients.

The panel recommended that Medicare carriers set up physician advisory committees to consider physician concerns about Medicare. These committees will be composed of medical directors of state medical associations, physicians who treat Medicare patients, and Medicare beneficiaries.

The report also expressed concerns about the peer review process. HCFA has developed a new strategy—the Health Care Quality Improvement Initiative—which will move the peer review organization (PRO) program from its emphasis on individual clinical errors to helping providers improve the mainstream of medical care. Under this new initiative, PROs will shift their focus from individual case review to analysis of patterns of medical care and outcomes, using an educational rather than punitive approach.

The panel also recommended that HCFA review the language used on the Explanation of Medicare Benefits form to ensure that it is easily understood and presented in a neutral tone. This process has been underway for some time within HCFA. Other recommendations included coordinating quality review of physician and hospital services, re-evaluating medical review procedures, and taking further steps to improve communications between physicians and carriers.

For a copy of the report, call the HCFA Philadelphia Regional Office at (215) 596-1351.

Diane C. Moskal
Acting Regional Administrator, HCFA Philadelphia

PHYSICIANS ADVISED ABOUT MA PROCEDURES

Editor's Note: The Pennsylvania Department of Public Welfare (DPW) has supplied the following information about Medical Assistance (MA) procedures affecting physicians and patients.

Automated admission certification

DPW implemented an Automated Admission Certification Process effective August 1, 1992. This process will automate the Diagnosis Related Group (DRG) review process for urgent and emergency admissions, and the Concurrent Hospital Review (CHR) process for all admissions to hospitals and units excluded from the DRG payment system. This change merged these two processes with the already automated Place of Service Review (PSR) Program for elective admissions to acute care hospitals, free-standing ambulatory surgical centers, and hospital short procedure units.

Prior to the Automated Certification Process, hospitals were required to submit a Hospital Admission DRG/CHR Certification (MA 87) form to DPW for urgent and emergency admissions and for all admissions to CHR facilities. Under the previous process, the patient may have already been discharged before the admission was reviewed by the department, placing the provider at risk of providing services with no commitment for payment from DPW.

Effective August 1, *facilities must call* DPW to certify all urgent or emergency admissions of MA recipients under the prospective payment system (provider types 06, 08, and 11), and all admissions of MA recipients to cost-reimbursed (CHR) hospitals and units (provider types 12, 13, and 53). Hospitals must contact DPW within two working days of the admission to the facility. A nurse reviewer obtains the information and issues a Hospital Admission DRG/CHR Certification Notice which will be sent to both the facility and the *attending practitioner*. The notice will include the department's decision on certification, and if approved, the 10-digit certification number.

For admissions on or after August 1, physicians and podiatrists are required to enter the 10-digit admission certification number in item 43 of the Physician's Invoice or Medical Services/Supplies Invoice (MA 319/MA 319C) for all primary care services provided to medical assistance recipients. The admission certification number is required when billing for types of service 20—Surgical, 25—Surgical Diagnostic, 60—Medical, 70—Pshyciatric, and 30—Obstetrical. The admission certification number is not required for consultations or other ancillary services.

Urgent or emergency admissions will continue to require that the emergency indicator "1", or the urgent indicator "2", be entered in items 29F, 30F, 31F, and/or 32F of the MA 319/319C invoice in addition to the admission certification number in item 43 of the invoice. Physicians are reminded that the facility is responsible for contacting DPW to have an admission certification number generated for urgent or emergency admissions or for all admissions to cost-reimbursed hospitals. The physician or podiatrist *cannot* call for an admission certification number in these instances.

The PSR process for elective admissions to acute care hospitals, free-standing ambulatory surgical centers, and hospital short procedure units remains unchanged. The attending practitioner still has the primary responsibility to initiate PSR requests. However, requests can be initiated by either the attending practitioner or the facility.

An Admission Certification Section will be issued for provider handbooks in the near future. In the meantime, information about certification can be found in the MA bulletin, "Automated Admission Certification," issued effective August 1, 1992.

Physicians should direct any questions to DPW at 1-800-537-8862.

Outpatient billing

Chapter 1101, Section 1101.63(b) (7), relating to co-payment for MA services, states that no provider may waive the co-payment requirement or in any way compensate the recipient for the co-payment amount.

If the recipient does not pay the co-payment, the provider *must* enter *visit code 11*, co-pay not collected, in the applicable visit code item of the invoice. Otherwise, DPW will have incorrect or incomplete data on which to base its co-pay rebate process. This will result in DPW issuing a co-pay rebate check to a recipient who had not paid the co-pay in the first place.

MA forms

DPW reminds providers that maintaining an adequate supply of MA forms will help ensure that providers can bill the department promptly for services rendered to MA patients. It also ensures that any special services required by the patient through the Prior Authorization or Administrative Waiver processes can be requested promptly.

The Medical Services/Supplies Prior Authorization Request (MA 97) is required for a provider to prescribe a service or item which requires prior authorization, and the 1150 Administrative Waiver Request (MA 325) form is used to request the department to consider payment for items or services not on the MA Fee Schedule.

All MA forms are ordered using the MA Provider Order Form (MA 300X). Although MA 325 is not listed on the current MA 300X, these forms may be ordered from the forms contractor in packs of 25. To order forms, complete the MA 300X and send it to DPW MA Forms Contractor, P.O. Box 717, Mechanicsburg, PA 17055.

For more detail on forms reordering, see the General Information Section of the *Physicians' Services Handbook*. Become familiar with this section and make sure an adequate forms supply is always on hand, even of seldom-used forms. Direct questions about reordering to the Division of Outpatient Programs, P.O. Box 8046, Harrisburg, PA 17105.

AHCPR PUBLISHES FIRST THREE PARAMETERS

The Agency for Health Care Policy and Research (AHCPR), U.S. Public Health Service, has published three clinical practice guidelines, also known as practice parameters. The guidelines include information of proven clinical value relating to *Acute Pain Management; Urinary Incontinence in Adults;* and *Prediction, Prevention, and Early Intervention of Pressure Ulcers*.

The parameters are the first in a series of such documents which cover a wide variety of medical topics. They are designed to give physicians scientifically validated information which can positively affect patient outcomes. Some highlights:

- Standard practice for pain control may fail to relieve pain in about half of post-operative patients.
- Unrelieved pain or trauma can delay recovery.
- When pain is controlled, patients tend to be discharged from hospitals earlier and may have fewer chronic problems, such as phantom limb pain after amputations.
- Most cases of urinary incontinence can be significantly improved or cured, yet half of those affected never seek medical help.
- Most pressure ulcers can be prevented with careful attention to patient risk factors.

Guidelines are developed by private panels of recognized experts representing a broad spectrum of physician/specialties and other health care professionals; panels also include representation by patients/consumers. A total of 16 topics have been identified for guideline development.

The parameters are published in three formats, including a clinicians' version, a quick-reference guide for health professionals, and a patient/consumer pamphlet (also available in Spanish) suitable for distribution by hospitals or physicians' waiting rooms.

All guidelines are available without charge from: AHCPR Publications Clearinghouse, P.O. Box 8547, Silver Spring, MD 20907.

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HCFA and the Political Scene

Donald E. Harrop, MD

Will the fact that this is a presidential election year affect the philosophy and direction of the Health Care Financing Administration as it relates to health care financing in general and the peer review organization program in particular? Perhaps.

Some people seem to think that if a particular presidential candidate is elected in November, they can expect to see some dramatic changes in the U.S. health care system—changes which will be beneficial to themselves and the nation as a whole. I'm not sure it will be that simple.

We have to keep in mind that the overwhelming majority of the people who administer the financing and oversight of programs such as Medicare, Medicaid, Maternal and Child Health, etc., are federal employees—career bureaucrats who are not responsible to any political party. Of course, the heads of the various departments and agencies, such as the secretary of Health and Human Services, are usually political appointees who often have specific agendas. But even then, changes in direction do not occur overnight.

Changes in the appointments, however, do occur quite often, some by choice and some by political pressure. For example, in just the last few years, we have seen several different administrators of the Health Care Financing Administration (HCFA), from William Roper to Gail Wilensky to now Acting Administrator William Toby.

Dr. Harrop is president of the Keystone Peer Review Organization.

Recently, there have also been a number of changes in other top management positions within HCFA, especially those directly involved with the PRO program. This type of musical chairs does not usually allow for quick and easy implementation of new policies.

Meanwhile, the career federal bureaucrats go along doing things mostly their way. Even Congressional mandates are not always carried out in accordance with the intent of the lawmakers and sometimes are not carried out at all. For example, PRO denials for substandard care, required by the Omnibus Budget Reconciliation Act (OBRA) of 1985, were never implemented and probably never will be.

PROs will implement the Fourth Scope of Work during 1993, with some significant changes scheduled for the overall structure of the program regardless of whom is elected. HCFA has proposed the formation of Clinical Data Abstraction Centers (CDACs) which would do the abstraction of medical records using the Uniform Clinical Data Set (UCDS). Cases that fail the UCDS screens would be returned to the PRO for traditional review. Another important shift in operating philosophy will reduce emphasis on individual case review in favor of analysis of trends.

The one major change which could occur as a direct result of the presidential election would, of course, be the development of a national health insurance program. Every candidate has expressed concern over the costs of health care and the need for insurance coverage for all citizens. A sound method of financing any of the proposed solutions to the problem has yet to be offered. Therefore, although I believe we will eventually have a national program of some type, I doubt that it will be enacted during the tenure of the president who is elected in the fall of 1992.

As I see it, there will be one constant: the move toward managed care which the present administration and many government officials perceive to be a viable approach to cost control. I certainly hope they also consider the necessity for controlling and assuring quality of care.

QUARTERLY REPORTS FROM KEPRO OVERSEERS

The House of Delegates, through Resolution 86-44 (Amended), has mandated the Society to provide regular reports on Keystone Peer Review Organization (KePRO) findings. The following report from the Ad Hoc Committee on KePRO Oversight covers the period April 1 through June 30, 1992. It shows the number of Medicare discharges, cases reviewed by KePRO physician reviewers, pending denials issued, final denials issued, and DRG changes made by KePRO.

KePRO Data for All Pennsylvania Hospitals—04/01/92 - 06/30/92

Medicare Discharges	*169,832	DRG Changes	1,484
Cases Reviewed	41,082	PPS Hospitals Under IR	0
Admission Denials	685	Generic Screen Failures	34,279
Adminstrative Denials	212	Pending Quality Problems	6,546
Total Denials	897	Confirmed Quality Problems	452

** Reflects total discharges received by KePRO for the reporting quarter.*

One to One.

One to One is a series that invites physicians to ask questions about Pennsylvania Blue Shield.

We've designed *One to One* to be another open line of communications between physicians and Blue Shield. Our goal is to give you the opportunity to ask questions — and to give us the chance to provide physicians with information about both our Private Business and Medicare operations.

Your questions will be addressed by Joseph A. Ricci, M.D., Blue Shield's Vice President of Medical Affairs. If you have a question, please write Dr. Ricci at Pennsylvania Blue Shield, P.O. Box 890089, Camp Hill, PA 17089.

What is Medicare's PAL process?

PAL is the acronym for Provider Audit List. The PAL process is one of Medicare's methods of reducing misreported services on claim forms and reflects each carrier's responsibility to protect the fiscal integrity of the Medicare program.

This process identifies providers whose practice patterns indicate the potential for misreported, over-utilized or misutilized services. The PAL process compares a provider's practice patterns to his peers and when necessary, educates the provider and his office staff about any claims reporting mistakes they are making.

The Health Care Financing Administration (HCFA), the federal agency that administers Medicare, requires all of its carriers to conduct five PAL audits for every 1,000 active Medicare providers for whom it provides reimbursement for medical services. Pennsylvania Blue Shield is the Medicare Part B carrier for Pennsylvania, New Jersey, Delaware and the Washington, D.C. metropolitan area. With 56,160 active Medicare providers in this region, Blue Shield is carrying out 281 audits during 1992.

How are the providers chosen for the PAL?

If you have been slated for a PAL audit, Blue Shield picked you after reviewing your practice patterns and the amount of reimbursement you receive from Medicare. The practice patterns are compared to other providers in your specialty, who practice in the same geographic region. If you have a higher than normal rate of utilization for one or more procedures, then Blue Shield will take a closer look at this utilization through an audit.

When Blue Shield decides to audit your practice, the Company is merely searching for reasons why these abnormal swings in utilization have occurred. In doing so, we make every effort to examine all the facts that pertain to the case, to ensure a fair audit.

And, although we routinely request refunds from providers who have received over-payments due to the misreporting of services, the main thrust of a PAL audit is educational. Blue Shield wants providers and their office staffs to be aware of what services are eligible under Medicare and what reimbursements they can expect.

How is the audit conducted?

Blue Shield notifies you that it is planning an audit and asks for patient records that pertain to the potential problem. In most cases, the review focuses on specific services or procedures.

Many times we can resolve the issue simply by examining the patient records. If further data is needed, however, it will be collected and then reviewed by one of Blue Shield's Professional Consultants. These consultants are active practitioners in the same specialty as the provider under review.

Then, based on a review of the data collected and the consultant's recommendations, Blue Shield determines what, if any, action should be taken.

Do you have any suggestions for providers who may be audited?

Yes, please remember that this process was not designed to "hassle" physicians. Our goals are to educate providers and their office staffs on proper billing procedures and to ensure that Medicare funds are used properly — and only for medically necessary services.

Also, in order to protect yourself and to make sure that any review or audit can be conducted easily, you should keep complete, explicit notes on every procedure or service you perform. Well-documented records clearly detail each medical visit. They also allow reviews to go smoothly — irrespective of the reviewing entity.

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COMMISSION APPROVES PUBLIC HEALTH PLAN

The Commission on Public Health, at its June 18 meeting, approved a public health plan for the State Society. This is the Society's first attempt to create a plan to guide its efforts in the public health arena.

The plan was created in response to recommendations made by Robert N. Moyers, MD, Society president, in a speech to the 1991 House of Delegates. He suggested four planning phases: 1) focus on education and community based programs, and maternal and infant health; 2) identify ways in which the Society can help to solve a number of public health problems; 3) develop the Society's plan of attack; and 4) build a coalition to help with implementation.

The commission's plan addresses the first two phases of the process outlined by Dr. Moyers by identifying priorities—education and community based programs, maternal and infant health, tobacco usage, alcohol and drug abuse, violent and abusive behavior, unintentional injuries, HIV, and environmental health—and outlining general actions which the Society could undertake.

The plan was presented to the Society's Council on Education and Science in August, and, assuming approval, will move to the Board of Trustees and House of Delegates for review and consideration. If both these groups accept the plan, the commission will then begin work on phases three and four.

PACE EXPANDS ProDUR PROCESS

The Pennsylvania Department of Aging, on August 16, 1992, extended its PACE Prospective Drug Utilization Review (ProDUR) to H_2-Receptor Antagonists and Nonsteroidal Anti-Inflammatory medications. Until August, the process, operational since February, had only been used for Halcion.

The State Society had previously expressed serious concerns with the expansion proposal, some of which were addressed by the following changes made to ProDUR in August:

- The criteria implemented are somewhat less stringent than those originally proposed.
- While the override mechanism has not yet been fully defined, a "Dear Physician" letter—dated July 17, 1992, and explaining the changes—contained a toll-free phone number for use by physicians and pharmacists when exceptional circumstances exist.
- One of the Society's nominess has been selected to PACE's Pharmacy and Therapeutics (P&T) Committee.

Though encouraged by the changes, Society representatives will continue to talk with the department about the adverse impact of ProDUR on medical practice. Physicians encountering problems with the process should call the Society's Department of Education and Science at 1-800-228-7823 with details.

CLIA RAISES TESTING COSTS

Federal regulations for implementing the Clinical Laboratory Improvement Amendments (CLIA) of 1988 are likely to increase the cost of medical testing both for physicians and patients, according to the CLIA Study Coalition.

The coalition—consisting of the AMA, American Hospital Association, Health Industry Distributors Association, and Health Industry Manufacturers Association—sponsored a study that found the regulations could increase the costs for physician office laboratories and hospitals by $409 million to $728 million during the first year. After the third year, the average cost of performing a single test could be 62 cents to $1.16 higher than it would have been without the regulations.

The coalition's study also estimates that about 4,000 of the nation's 88,400 physician office and clinic laboratories may be forced to close or confine their testing to a very few waived tests.

HEALTH EDUCATION COALITION TO FORMALIZE

As reported in March, the State Society is working with a coalition to mandate stronger school health education programs in Pennsylvania. Current law directs that each school district design its own curriculum.

The official adoption of coalition by-laws is expected during a fall meeting. Specific goals proposed include:

- to provide a statewide forum for awareness, communication, and information exchange to promote comprehensive school health education;
- to encourage continuing education programs for teachers to strengthen the teaching of health in grades K-12;
- to promote professional preparation of programs that will ensure the availability of well-qualified health educators to teach comprehensive health education to Pennsylvania students in grades K-12;
- to initiate and support legislation and public policy that will enhance comprehensive school health education; and
- to encourage development of local coalitions to advocate comprehensive school health education.

Currently supported by health care and education groups, the coalition hopes to broaden participation at the fall meeting. It will then use guidelines for health education to meet its goals, as well as seek support from state policymakers and lobby for mandated school health programs.

AMA ASKS CONGRESS TO MODIFY OSHA REGS

In response to a policy adopted at its recent annual meeting, the AMA has asked the House Labor/HHS Appropriations Committee to require the Occupational Safety and Health Administration (OSHA) to make changes in the implementation of the bloodborne pathogen standard.

The AMA wants OSHA to: reconsider the current penalty structure, conduct a cost/benefit analysis of the standard as it applies to physician practices, reduce the 30-year record-keeping requirement, and adopt a one-year grace period for physicians who are making good-faith efforts to comply with the standard.

The request was made by James S. Todd, MD, AMA executive vice president, in letters to Representative William Natcher (D-KY), chairman of the House Labor/HHS Appropriations Subcommittee, and Representative Carl Pursell (R-MI), ranking minority member.

SOCIETY TO HELP WITH CANCER EDUCATION STUDY

The State Society will help the National Cancer Institute of the National Institutes of Health with a study to determine the effectiveness of an educational program for physicians. The program is designed to help them counsel their patients on how proper nutrition and smoking cessation can reduce the risks of cancer.

Approximately 1,000 of Pennsylvania's primary care physicians were contacted this summer to participate in the study, which will review and test the program. One-third of participants will receive a formal continuing medical education (CME) program presenting counseling techniques, while the remaining two-thirds will receive materials and advice, without formal training, about counseling. The institute will then compare the opinions of the two groups to determine the effectiveness of the CME program.

The Society's primary role in the study is to review the CME program content so Category I credit may be offered to seminar attendees. The Society is also encouraging Pennsylvania physicians who were contacted by the institute to participate in the study.

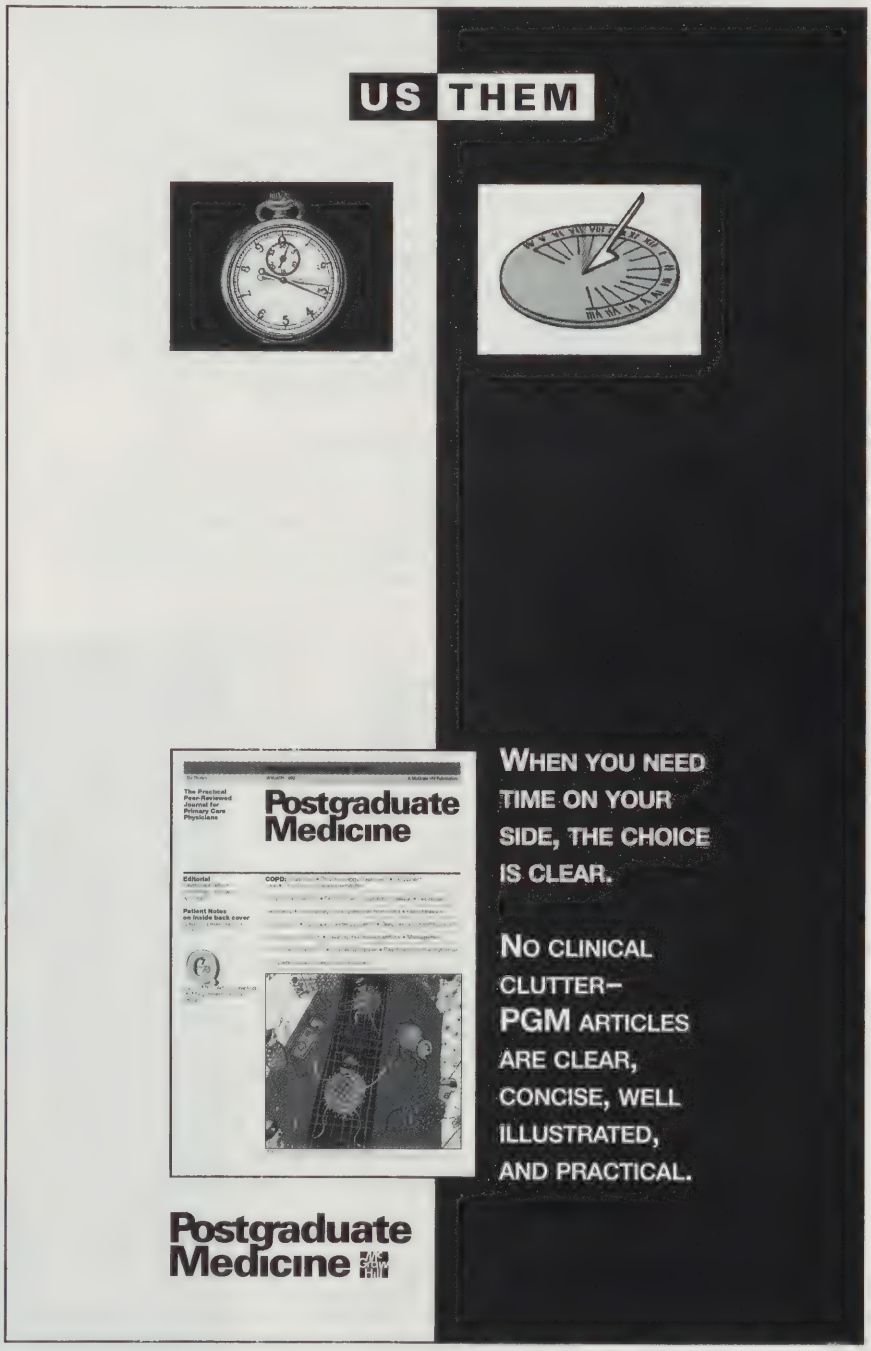
USP OFFERS REPORTING SYSTEM

The United States Pharmacopeia (USP) offers a nationwide reporting system enabling health care professionals to relay concerns regarding the quality, safety, or performance of the products used in their practices.

The USP Practitioners' Reporting Network (PRN) is comprised of four programs: 1) the USP Drug Product Problem Reporting Program; 2) the Medication Errors Reporting Program; 3) the Medical Device and Laboratory Product Problem Reporting Program; and 4) the USP-SNM Drug Product Problem Reporting Program for Radiopharmaceuticals. Each accepts observations and suggestions from physicians and other health care professionals on the four topics. After reviewing input, USP relays pertinent information to the appropriate organizations and agencies developing and revising standards. Thus, physicians' input may directly impact quality improvement.

For additional information about the network, for reporting forms, or to report concerns over the phone, call the USP-PRN at 1-800-638-6725. Also, to report medication errors confidentially and anonymously, if desired, call 1-800-23-ERROR.

Robert J. Lilley, the Society's assistant director of educational and scientific affairs, contributed to this page.



Developing A Patient Communications Plan

The Health Care Group

With today's trend toward consciousness-raising among physicians regarding good patient relations, many medical practices are giving increased attention to developing patient communications plans.Traditionally, this involves revisiting the appointment scheduling system, to be sure it is patient-oriented as well as an efficient use of time and resources. Next, well-managed practices adopt automatic patient recall systems, with accurate tickler and appropriate message content.

All too often, however, a formal communications plan stops there, with the rest of patient communications left to chance and good intentions. Unfortunately, this well-meaning proverbial paving may be filled with hazards to the office's communications vehicles.

Telephone systems

Perhaps no communications link offers more potential for success—or damage—than your telephone system. How many times have patients called medical offices and been greeted by busy signals? The answer is obvious, and yet we often wonder what would happen if the unsuccessful caller were a patient in an emergency. The office's mechanical unresponsiveness is simply one of the most grating experiences patients can have—certainly one that makes them feel the doctor is too busy to care.

A practice must have enough incoming telephone lines to serve its patients adequately. This is an obligation which should not be avoided by some casual feeling that the patients can keep trying until they "get through." Even if the office receptionist cannot handle any more lines, a variety of solutions exist, including adding a second receptionist, creating a separate insurance and/or business office line(s), and adding additional outgoing lines to clear the "in" lines. Even if the solutions carry additional costs, they should be acceptable both to properly serve existing patients and avoid real embarrassments.

Several absolute rules should be implemented regarding incoming phone calls. First, no calls should ever be placed on "hold" before the callers have had an opportunity to announce themselves and any special reason for their call. Second, no lines may be kept on "hold" for more than 30 seconds without someone speaking to the callers, if only to assure them that they have not been forgotten. In offices where one person has primary responsibility to answer the phone, there must be a clear identification of one or several of the assistants who have secondary responsibility to pick up and recontact callers on blinking "hold" buttons.

Publications

A brochure describing the practice, the services available, and credentials (in non-technical language) of the medical and other professional staff can prove immensely helpful and reassuring to patients.

A periodic newsletter can disseminate timely health education as well as practice-specific information. Physician newsletter materials are widely available commercially and usually provide for inclusion of personally prepared input.

And don't forget other publications. Why not set up a lending library of books, magazines, and cassette tapes about general health and topics within your medical specialty?

Patient surveys

Patient surveys are an important tool to identify aspects of a practice which need attention and improvement to better satisfy patients. Many doctors and managers agree with the concept but have trouble drafting questionnaires that they believe will get useful results. Since wrong or poorly worded questions can have a negative effect, try to:

- Keep it brief. Be sure each question is asked in a short sentence capable of a quick and simple reply.
- Avoid vague questions. Some survey questions fail to identify what the practice wants to learn.
- Avoid "yes-no" answers. Most people will answer favorably unless they are extremely dissatisfied, so a "yes" answer might not reveal the true situation. Give readers a range of choices or a graded scale (usually 1 to 10) from which to select.
- Don't plant bad seeds. While you may wonder if your practice fees are considered too high, we doubt they will be lowered in response to survey replies. If you won't or can't act on something, don't ask about it.
- Make signature optional. Some patients will prefer leaving their names so the practice will know their observations.
- Leave space for comments. Those comments will probably be the most useful of all.
- Have it nicely printed.

Service recovery

In the service sector, making things right in the face of complaints is called "recovery:"

- Detection. Though some employees may want to stifle complaints, that's the wrong attitude. Complaints point out areas of discontent which may be overlooked. Knowing about them gives the practice the opportunity to right a wrong.
- Correction. By righting the wrong, the practice presents itself more favorably to future patients. Thus the recovery system helps improve service.
- Reselling. By attempting to solve the problem a patient complained about, the practice "resells" that person on its values. The recovery process retains a patient's loyalty, and the recovered patient is more likely to praise the practice to others.

The importance of recovery may seem obvious. But how can you make the principle actually work in your office? Here are some ideas.

- Managerial emphasis. The physician(s) and the manager/administrator are basically responsible. They must make it clear to all employees that complaints are welcome. The job of the physician or manager is to make sure the staff understands this. Make it clear in job descriptions and performance evaluations that patient satisfaction is as important as efficient work.
- Complaint report. Develop a simple printed form that must be

completed for each patient complaint. Make sure each report is turned in to a designated person—perhaps the manager—to track problems and their handling.

• Reparations. Formalize a process by which each complaint receives some sort of special response. Whether it be a gift certificate, a dozen roses, or a personal apology letter or phone call from the doctor or manager, the gesture helps save the patient's loyalty. Assign the reparations task to one person—probably the office manager—so the gestures will actually occur.

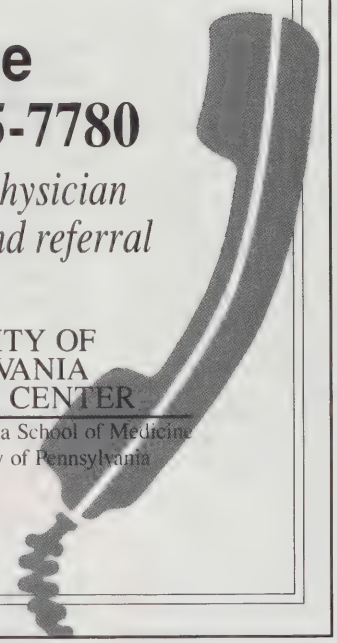
Properly administered, service recovery strategies do more than just save face. Patients feel more secure when they know the entire practice cares: their confidence and trust increases. And the staff benefits by having solid guidelines for concern, from which they feel pride in being part of a quality organization.

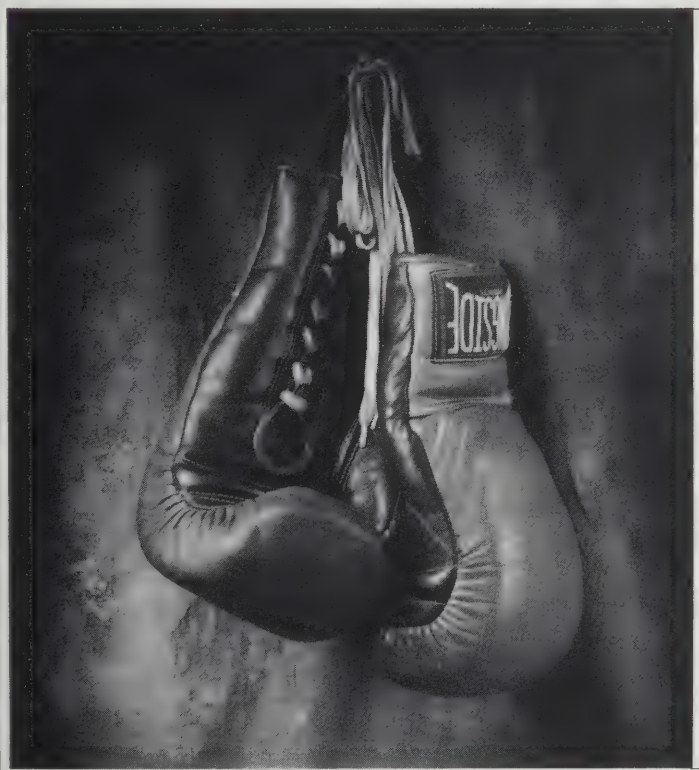
The contributing authors, Dorothy R. Sweeney and Paul W. Smith, are consultants with The Health Care Group, Plymouth Meeting.

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A Courtroom Lesson in Physician-Assisted Suicide

Mark V. Caliendo
Geoffrey E. Leber

Physician participation in euthanasia and assisted suicide has been the subject of long-standing debate and is unlikely to be resolved easily or soon. The Pennsylvania Medical Society's Medical Student Section explored this topic recently in a second "mock trial" held in conjuntion with the Temple University School of Law and cosponsored by the Pennsylvania Medical Society Liability Insurance Company. This is an account and essay from that trial.

The trial of Dr. C

The highly charged issue of physician-assisted suicide provided the scenario for the second annual medical issue mock trial. Medical and law students from across the state came to Philadelphia to participate in the trial of the hypothetical case of "Patient K" and "Dr. C" (see sidebar next page).

The trial pitted defense and prosecution teams of law students against each other, with medical students portraying the defendant, coroner, physician-expert witnesses, and jurors. Among the witnesses called were ethicists, oncologists, and psychiatrists. High school students interested in careers in law and medicine were the audience.

John Whyte, third-year medical student at Hahnemann University, and Temple-LEAP attorney David Trevaskis collaborated on creating this year's problem. "It was easy to write the problem," Trevaskis noted, "because all we had to do was outline the main issues. The really hard work of providing the facts of the case was done by the students."

Mark V. Caliendo serves as student representative to the State Society Board of Trustees. Geoffrey E. Leber is a member of the Society's Medical Student Section. Both are fourth-year students at Hahnemann University School of Medicine, Philadelphia.

Newspaper headlines have been occupied recently with accounts of retired pathologist and self-proclaimed "Dr. Death," Jack Kevorkian, MD. Dr. Kevorkian gained notoriety in the summer of 1990 for his role in helping 54-year-old Janet Adkins kill herself with his infamous "suicide machine."

Dr. Timothy Quill followed suit in March 1991 by revealing his participation in the suicide of his patient, Diane, who was diagnosed with acute leukemia. Dr. Quill prescribed, at Diane's request, the barbiturates she used to end her life after electing not to undergo chemotherapy.[1] In 1988, "It's Over, Debbie," an essay describing the actions of a resident hastening the death of a young woman dying of ovarian cancer, appeared in a major medical journal.[2]

The Public Health Service reports that approximately 75 percent of all deaths in 1987 occurred in hospitals and long-term care institutions, up from 50 percent in 1949, 61 percent in 1958, and 70 percent in 1977.[3,4,5] Public awareness and concern regarding medical decisions that lead to patients' deaths are heightened as a result of this move of the locale of death from the sanctity of the home to medical institutions, e.g., decisions made at these facilities are more subject to review and thus more likely to enter public consciousness.[5] Moreover, American Hospital Association statistics estimate that many of the nearly 6,000 daily deaths in the United States are somehow planned by patients, families, and physicians, while a remarkable 53 percent of respondents in a recent *New York Times*-CBS poll believe that doctors should be allowed to assist a severely ill person in taking his or her own life.

Author Kurt Vonnegut went so far as to envision "ethical suicide parlors" set up around the country to encourage people to end it all. Although seldom as eccentric as Vonnegut's vision, instances in which physicians might act to hasten death or refrain from prolonging life generate a variety of feelings from members of the medical profession and lay community alike, and should be the basis for further individual and collective evaluation.

Physicians and the legal process

The need for a familiarity with the legal process has long been a fact of professional life for physicians, and contact with the courtroom is more prevalent now than ever before. During the Roman Empire, a physician named Antistius examined the bloody remains of Julius Caesar and later performed superbly on the witness stand: of the 23 stab wounds inflicted, he testified, only one was mortal—perforation of the thorax.

A significant number of contested cases at the trial level require medical evidence, compelling practically all physicians to testify in court at some time during their careers. For some medical specialties a court appearance is a regular occurrence.

Furthermore, the specter of malpractice liability suits has haunted the medical profession since at least the code of Hammurabi in early Mesopotamia. Today's penalties for malpractice are still a source of anxiety and frustration for many physicians, particularly those who will soon sink or swim in the murky waters of twenty-first century practice. Thus, the opportunity to participate in the mock trial (see sidebar at left) is as important to efforts to become well-rounded, knowledgeable future physicians as learning how to write a prescription.

This year's mock trial is an indication of how ethical-medical decision making has moved beyond the realm of academic medicine to the mass media, from behind the closed doors of physician's offices

onto the front pages. In Washington state last November, a controversial and bitterly fought proposal to legalize euthanasia failed narrowly; similar efforts were launched in California.

Likewise, Dr. Kevorkian again made national headlines with an outline of his proposal, published in the *American Journal of Forensic Psychiatry*, for a new medical specialty of euthanasia practitioners. This specialty would be called "obitiartry": the practice—"medicine"; the practitioners—"obitiatrists."

Suicide vs. euthanasia

In this country, euthanasia is commonly defined as an act or method of causing death painlessly to end suffering, particularly as a way to deal with persons dying of incurable, painful diseases. However, euthanasia differs from assisted suicide in the extent of physician participation. For instance, in euthanasia the physician performs the immediate life-ending action (e.g. administering a lethal injection), while assisted suicide occurs when the patient performs the life-ending action facilitated by the physician offering the means.

Withdrawal of life-sustaining treatment, or "passive euthanasia," as well as the over-administration of palliative treatment to relieve pain and suffering and allow death as a foreseeable side effect, are being performed less infrequently in many medical settings. Of course, the ultimate question is: Where do we draw the line?

Dr. Kevorkian is viewed by many as the nation's most radical proponent of euthanasia, though he is certainly not without his supporters. Proponents often cite the Netherlands, for example, where euthanasia is performed openly and commonly, under the auspices of the Dutch Medical Association and the government, as a proven model of euthanasia.

Euthanasia is permitted in the Netherlands when four conditions are met: 1) severe suffering exists without the hope of relief; 2) a financially and emotionally uncoerced, informed, and consistent choice has been made by the patient; 3) other treatment options are not available; and 4) second opinions have been obtained from other professionals.[6] Estimates reveal that 5,000 to 10,000 Dutch die annually by euthanasia.[7]

Another argument in favor of euthanasia is based on the constitutional rights of the individual. Those who oppose sanctioned euthanasia consider the civil rights not just of those who would want euthanasia themselves, but of all citizens. They argue that euthanasia is an unacceptable public policy because of the inevitability in involuntary euthanasia of persons being killed without consent.

Singer and Siegler cite four examples of how voluntary euthanasia could lead to involuntary euthanasia: 1) "crypthanasia" or secret euthanasia involves killing vulnerable patients without their consent; 2) "encouraged" euthanasia, whereby chronically ill or dying patients may be pressured to choose euthanasia to spare their families or friends financial or emotional strain; 3) "surrogate" euthanasia, which permits euthanizing incompetent patients on the basis of substituted judgment or burdens versus benefits; and 4) "discriminatory" euthanasia, or coercing vulnerable groups in society to request euthanasia, such as the elderly, disabled, indigents, or those with the acquired immunodeficiency syndrome.[8]

Also, some argue that euthanasia violates fundamental standards of medicine, because it diverts attention from central issues in the care of dying patients—including better pain control and improved management of the dying process as in hospice care—and subverts the time-honored role of physician as healer outlined in the Hippocratic Oath.[8]

Physicians might act to hasten death through assisted suicide when conflicts occur between the duty to relieve suffering and the duty to preserve life. Advocates suggest that assisted suicide is a natural progression of the principle that hopelessly ill patients may refuse life-prolonging medical care. Society has increasingly recognized the right of patient autonomy, which entitles each person to decline life-sustaining treatment in order to eliminate prolonged suffering. Theoretically, suicide would also put an end to suffering that could be considered needless and would be a fulfillment of the patient's desires.[9]

On the other hand, opponents contend that the primary purpose of assisted suicide is to cause death, while drawing the distinction that withdrawal of treatment permits death to take its natural course. Once again, they argue that assisted suicide, like euthanasia, might undermine the basic foundation of the physician-patient relationship, the patient's trust that the physician is wholeheartedly devoted to caring for the patient's health. Physician-assisted suicide creates the risk of "slippery slope" abuses or mistakes resulting in a potential deterioration of public respect for physicians.

Another scenario raised by those against assisted suicide is that of patients whose disease or pharmacological treat-

The case of Patient K

Patient K was a 55-year-old woman with a lifetime of memories, dreams, and reflections. She also had a 30-year history of smoking more than a pack of cigarettes a day. The smoking gave her a certain pleasure at times in her youth; in her early fifties, however, the smoking led to small-cell lung carcinoma. Indeed, at the time she took her life, her cancer had progressed to stage IV: weight loss, bone pain, and a general malaise—not to mention side effects from chemotherapy and radiation therapy—had overtaken her prior to her death.

Dr. C had been her primary care physician for a number of years, and watched recent suffering. She and Dr. C had talked openly of her pain and of her desire to take her own life. Although he had deep reservations about any patient giving up the fight for life, Dr. C was convinced that Patient K knew best about the choices she was making.

Dr. C had refused to help when Patient K asked him for the first time to provide her with drugs to take her life. He had been struck by her knowledge that a proper dose of potassium could take a life without much trace of evidence. As time passed and they discussed cases involving the doctor in Michigan and his "suicide machine," Dr. C realized that he wanted to help Patient K end her pain and suffering.

Finally, after being asked nearly 20 times over the period of a year for assistance in taking her life, Dr. C told her that he would help her do whatever she chose to do. He prepared a lethal dose of potassium for her and explained she could inject herself with it through her Hickman catheter. He gave Patient K the syringe and told her to take it home and think over her decision.

Patient K went home, wrote a long note to her family and friends, and killed herself with the potassium injection. In her note she explained that she did not want anyone to blame the physician for giving her the potassium, as "he was only following my wishes." Police found the note and the syringe. After an investigation by the coroner, Dr. C was arrested and charged with aiding a suicide, a form of criminal homicide under 18 Pa.C.S. section 2505.

ments have progressed to impairing their decision-making capacity, making it difficult to ensure that a competent decision is being made. Finally, some patients may choose death because they feel that others might consider them an emotional or financial burden, or that society might prefer to spend increasingly limited health care resources on more compelling needs.

Thoughts on euthanasia

The Wall Street Journal reported recently (February 26, 1992) that one in every seven health care dollars spent annually is on the last six months of someone's life, raising questions of effective allocation of health care resources. With 12.5 percent of the American population over the age of 65, and life-prolonging technologies accounting for as much as 25 percent of our annual health care cost inflation, some proponents of assisted suicide assert that critical care, originally intended for patients with treatable illnesses and a reasonable chance of recovery, is a "sinkhole for resources."

By allowing our terminally ill population the alternative to seek a voluntary, conscientious, and dignified death, and at the same time ease health care cost escalation, we are providing a noble service to society as a whole. There are those that feel that a patient's motivation to spare family and friends the emotional and financial burden of watching his or her slow, painful demise does not appear to be unquestionably irrational.[10] Perhaps physicians are not always empowered to supply patients with health, but rather to supply them with help. However, opponents warn that legalizing assisted suicide places elderly patients in nursing homes at risk: those who become financially strapped or over-burdensome may be subtly influenced to request suicide.[11]

We are also reminded that as the debate proceeds, we must avoid romanticizing suicide, regarding it simplistically, by allowing negative attitudes toward aging to influence its course or by confusing the right to die with the equally important debate about allocating limited health resources to terminally ill patients. It has also been suggested that as we contemplate the ethical dilemma of assisting someone toward death, we must consider three nonpartisan prerequisites: 1) the request to die must not stem from a treatable depression; 2) the request must not stem from treatable discomfort, symptoms, and pain; and 3) the request must take place within the context of a relationship between physician and patient of some duration, depth, and intimacy.[11] It seems clear that we need to address the access to expert care of distressing symptoms including pain and psychological illness, in addition to the overall quality of life of this patient population, before we can fully weigh the options for terminating life.[12]

The medical community must improve its understanding of major predictors of patient outcome. Rapidly expanding technical abilities to collect and manipulate large amounts of detailed clinical data have created a new intellectual and technological basis for estimating outcomes from intensive medical care. We must strive to reduce uncertainty about difficult clinical decisions with the goal that physicians, patients, and society can reorient health care toward more scientifically and ethically defensible approaches.[13]

In the meantime, to avoid disputes, we must encourage all adults to prepare documents, including living wills and durable powers of attorney, that would provide guidance, if necessary, for their families and physicians; and encourage health care facilities to provide an opportunity for patients to prepare such documents on admission.[14]

Finally, those who urge drawing the line toward legalized euthanasia and assisted suicide remind us that, with the recently legalized concept of "self-determination," if a patient really wants to commit suicide, and is mentally competent to make such a decision, the means are there to do it without a physician's assistance.

The jury of our peers, brandishing polished weapons of wisdom and insight, further reminds us that in an era in which the discipline of medical ethics has become so widely publicized, we need to teach moral reasoning in medical schools and hospitals. It is easy to recognize that part of the public loss of faith in physicians is because of our paternalistic and sometimes cruel insistence on life at any cost.

The spiritual meaning of life and death is too complex to hold the rigid view that physicians should never assist in suicide. Death is not the enemy for many people, but instead is sometimes a welcomed relief to either a life fully lived or a life plagued with the ravages of incurable disease.

For the physician to arrive at an answer to this moral dilemma requires a deep exploration and definition of one's personal values. Nevertheless, our peers unanimously acquitted the defendant in this year's mock trial.

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SURVEY REVEALS OPINIONS ON HEALTH CARE ISSUES

Forty-seven percent of Pennsylvania residents perceive high or rising costs as the main problem facing health care and medicine today, according to a study by the Gallup Organization contracted by the Pennsylvania Medical Society. The 1992 Public Opinion Poll revealed that cost issues significantly outweigh quality, access, and other issues among Pennsylvania residents. These results are fairly consistent with national data (see Figure 1).

The poll was primarily conducted to identify perceptions about the problems facing U.S. health care, to examine physician relationships, and to assess perceptions about health care costs. Questions addressed general physician care, physician communication, health care reform, and other topics. The following is a partial summary of poll results.

General physician care

Pennsylvania adults were asked their level of agreement with selected statements regarding physicians in general. Respondents felt most agreement for doctors being up-to-date on the latest advances in medicine and for doctors taking a genuine interest in patients. They were concerned, however, about access for the poor and elderly, and the cost of care.

Other results show that 87 percent of Pennsylvania residents have a personal physician, as opposed to 79 percent nationally; 67 percent visited a physician within the last six months, and 63 percent felt there were "the right number" of doctors in their community.

Physician communication

Regarding physician communication, consumers were asked whether or not they have discussed treatment options, fees, medications, preventive information, and the risks of selected behaviors. A majority (75 percent) reported discussing treatment options prior to treatment, and more than one-third (37 percent) reported discussing fees with their physician.

Nearly two-thirds (64 percent) of Pennsylvania respondents reported reviewing all drugs and medications they were taking the last time the physician recommended a treatment or prescribed a drug. This proportion was nearly identical to that found nationally (66 percent). Also, 73 percent of the respondents said they discuss preventive medical information with their physician.

Regarding the question, "Has your doctor talked with you about the health risks of any of the following,?" Pennsylvanians responded favorably as follows: smoking—60 percent; alcohol abuse—42 percent; and drug abuse—38 percent. One in eight Pennsylvania adults reported having discussed living wills or the removal of life support with their physician.

Health care reform

The health care reform section of the poll posed questions regarding awareness of and preference for specific reform proposals. Results show that Pennsylvania adults prefer government-financed national health insurance for everyone (48 percent) over approaches requiring individuals to buy insurance (20 percent) or employers to provide insurance (29 percent).

Few respondents could name specific health care reform proposals without help, but when proposals were listed, 37 percent said they had heard of Health America, 20 percent had heard of Health Access America, and 18 percent had heard of the Pepper Commission.

Look for a follow-up article in the October issue of PENNSYLVANIA MEDICINE.

FIGURE 1

Main Problem Facing Health Care and Medicine*

*Poll results are based on 408 interviews among adults in Pennsylvania in spring 1992. The margin of error is 5 percent.

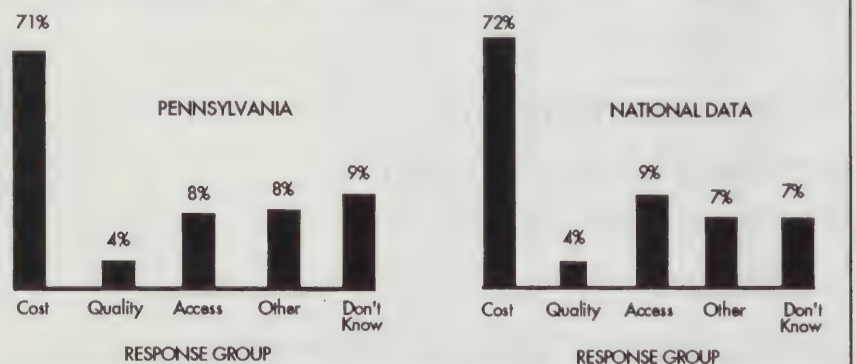


Figure 1 compares state and national responses to the 1992 Gallup Poll question: "Thinking about everything that has to do with health care and medicine, what do you think is the main problem facing health care and medicine in the United States today?"

Delegation News

PA "INFLUENTIAL" AT AMA ANNUAL MEETING

The Pennsylvania delegation to the AMA was at the forefront on several issues during the AMA House of Delegates' annual meeting in June. According to Howard A. Richter, MD, delegation chairman, "the delegation was enormously influencial on the floor of the House."

Of 16 resolutions proposed by Pennsylvania, three addressed significant issues of concern to physicians nationwide. In response to Pennsylvania's efforts, the AMA will develop: 1) policy regarding practice parameters, 2) mechanisms to study resource based relative value scale (RBRVS) problems, and 3) policy on concurrent care.

Practice parameters

The House of Delegates adopted an amended Pennsylvania resolution directing the AMA to work aggressively with the Agency for Health Care Policy and Research (AHCPR) and similar groups in developing, reviewing, and updating practice parameters. The first three clinical guidelines, designed to give physicians scientifically validated information which can positively affect patient outcomes, were released this summer (see Medical Economics, page 34).

The AMA has said it will support only those parameters developed by or in conjunction with physician organizations, and it will oppose the release of others to the public without physician review.

RBRVS

Physicians nationwide agree that a number of inequities exist in the implementation of the new Medicare payment system. Among those are reduction of allowances for new physicians, non-payment of EKG interpretations, and defects in cost indices and area designations, just to name a few. The AMA House of Delegates, through a Pennsylvania resolution, directed the AMA to take all necessary legal, legislative, and other action to address those and other RBRVS implementation problems.

Specific components in need of evaluation include clinical vignettes and other examples used to determine RBRVS values and payment levels; the work relative value unit (RVU) component; modifiers, including global descriptors; and global surgery fees.

The AMA, in response to the resolution, will also seek an additional comment period, support improving the accuracy of the Medicare geographic practice costs indices, support further study of refinements in the practice cost component of the RBRVS, and pursue adjustment of all RVUs to comply with increasing federal and state regulatory requirements.

Concurrent care

Confusion over appropriate and timely payment of concurrent care is an issue nationwide, as was apparent by four resolutions submitted on the issue at the House's annual meeting.

Pennsylvania's contribution requested that the AMA use all appropriate resources to 1) accomplish uniformity among carriers in the application of concurrent care payment policies in the Medicare program, and 2) allow physicians to be identified by the specialty as reported to the carrier rather than an arbitrary definition as established by a carrier for the purpose of concurrent payment policy.

The House of Delegates adopted Pennsylvania's resolve as part of a substitute resolution, which also directs the AMA to seek enactment of federal legislation and/or a change in HCFA policy to establish more equitable standards for fair and prompt payment for concurrent care for both primary care and specialist physicians, and seek uniformity among Medicare carriers and other third-party payers in application of concurrent care policies.

A report on concurrent care and related concerns will be presented to the 1993 AMA House of Delegates.

AMA-HMSS

Pennsylvania's Hospital Medical Staff Section (HMSS) representatives were also influential at the AMA level. Topping the list of timely resolutions submitted to and adopted by this year's AMA House is Resolution 156, Health Maintenance Organization (HMO) Establishment of All-Inclusive Reimbursment.

The resolution, as amended, calls for the AMA to investigate the legality of HMOs and any third-party payer reimbursing a hospital and its hospital-based physicians, including independent billing physicians, through an all-inclusive rate which would be paid to the hospital; and in the event it is determined to be legal, support legislation to assure patient and physician protection.

The AMA—in response to resolutions from several states, including Pennsylvania, and with the support of the HMSS—will also work toward a more rational definition of contaminated medical waste and a more rational policy for disposal. Additionally, the AMA-HMSS will urge hospital chief executive officers to seek modification of the American Hospital Association's health care reform proposal.

Women in Medicine

MONTGOMERY COUNTY PRESIDENT INDUCTED

Robert L. Schneider, MD, was inducted as the 145th president of the Montgomery County Medical Society (MCMS) for 1992-93 at the county society's annual dinner dance in June. Dr. Schneider has been a member of MCMS for seven years and active in the State Society since her residency days.

On a county level she has served as president elect, vice president, board member, delegate to the State Society, member of the Medical-Legal Committee, and board member of the Political Action Committee. On the state level, she is a voting delegate in the AMA, chairman of the By-Laws Committee, and vice chairman of the Task Force on Drug Abuse.

A board-certified emergency physician, Dr. Schneider completed her training at the Medical College of Pennsylvania, Philadelphia. She currently serves as director of clinical research at Sterling Winthrop Pharmaceuticals, Malvern.



Dr. Schneider

As for MCMS in the next year, Dr. Schneider plans the continuation and expansion of the society's role in support of public health initiatives to foster stronger ties between the medical and political communities.

County News

PHYSICIANS, LAWYERS DISCUSS "SAFE HARBORS"

More than 100 lawyers and physicians attended an annual medical-legal seminar, sponsored by the Montgomery County Medical Society (MCMS) and the Montgomery Bar Association, to discuss recently passed "safe harbor" (anti-kickback) rules.

W. Thomas Berriman, a hospital attorney, spoke about recent legislation designed to prevent hospitals and physicians from reaping excessive profits under the guise of providing patients with state-of-the-art medical care.

William H. Mahood, MD—a member of MCMS, the State Society, and the AMA's Council on Medical Services—reported that the AMA agrees with much of the "safe harbor" legislation. He made no apologies for the "greedy bad apples" in the profession and supports "weeding them out."

Finally, the seminar moderator, Lindly W. Cowperthwait, a past president of the Pennsylvania Trial Lawyers Association, declared empathy for physicians who found themselves accused of overmedicating and overtreating as rationalization for what is believed to be too high a cost for health care.

GASTROENTEROLOGISTS STUDY DEVELOPMENTS

Pennsylvania's gastroenterologists learned to apply recent developments in the medical and surgical

management of inflammatory bowel disease during the Pennsylvania Society of Gastroenterologists' Annual Scientific Meeting, September 11-13, in Harrisburg.

The meeting began with a welcome reception and banquet Friday night. Half-day scientific sessions presented Saturday and Sunday consisted of an inflammatory bowel disease symposium and a liver disease panel with case presentations. The seminar concluded with a session on "Managed Care: What Physicians Need to Know."

Program faculty included: Arthur B. Abt, MD, Hershey; Theodore M. Bayless, MD, Baltimore, Maryland; Robert B. Edmiston, MD, Camp Hill; Franz Goldstein, MD, Wynnewood; Graham Jeffries, MD, Hershey; Walter A. Koltun, MD, Hershey; William H. Mahood, MD, Flourtown; Thomas S. Mangan, MD, Danville; James C. Reynolds, MD, Pittsburgh; and David VanThiel, MD, Pittsburgh.

SOCIETY DISTRIBUTING LEGAL REFERENCE

The State Society recently began distribution of a reference created exclusively through Society resources, *Laws and Regulations Affecting Medical Practice*.

The volume is a 45-chapter reference on the legal rights and responsibilities of Pennsylvania physicians regarding such issues as abortion, antitrust, motor vehicle code reporting, medical records, withholding life support, and many others.

Written and carefully scrutinized by legal experts in the various areas, it provides insight and clearly described guidance specifically for physicians.

Because the Pennsylvania Medical Society Liability Insurance Company (PMSLIC) believes this fills an unmet need for Pennsylvania physicians, its board of directors unanimously voted to provide each PMSLIC insured with a free copy and all subsequently issued updates, as a policyholder service. Distribution to PMSLIC insureds began in August.

Non-PMSLIC Society members interested in obtaining a copy of *Laws and Regulations Affecting Medical Practice* should contact the State Society's Physician Services Department at 1-800-228-7823. The cost is $55 for Society members and $110 for non-members.

PMSLIC ISSUES SEMI-ANNUAL CLAIMS STATISTICS REPORT

The Pennsylvania Medical Society House of Delegates Resolution 86-17 requires that the Pennsylvania Medical Society Liability Insurance Company report certain claims statistics to the House of Delegates on a semi-annual basis.

In response to this resolution, PMSLIC published the first semi-annual report in the September 1987 PENNSYLVANIA MEDICINE. The data included in the following tables is an update of the most recent five year's experience of the data requested by the resolution.

Table 1: Joinders—Includes PMSLIC physicians joined by other parties and other parties joined by PMSLIC.

Table 2: Number of claims and suits filed by specialty, July 1, 1986 - June 30, 1991.

Table 3: Cost of claims and suits filed by specialty, July 1, 1986 - June 30, 1991.

Questions or comments should be directed to Lori A. Bartholomew, Acting Director of Governmental Relations & Research, PMSLIC, P.O. Box 8375, Harrisburg, PA 17105-8375.

TABLE 1

Number of cases in which a physician is joined as an additional defendant by a hospital or physician

Since beginning tracking joinder data on April 1, 1987, 95 PMSLIC insureds were joined by other parties through June 30, 1992, as follows:

PMSLIC Insured Joined By:	Number of Times:
Hospital	45
Other Physician	23
Nursing Home	3
Drug Company	1
Commercial Business	6
Plaintiff	4
Pharmacy/Pharmacist	6
Manufacturer	1
Other	6
TOTAL	**95**

During the same period, PMSLIC joined 20 other parties, as follows:

Party Joined By PMSLIC	Number of Times:
Hospital	2
Physician	10
Drug Company	1
Manufacturer	3
Other	4
TOTAL	**20**

TABLE 2: Number of claims filed by specialty from July 1, 1987—June 30, 1992*

Specialty	Number of Claims
Allergy	8
Anesthesiology	134
Cardiology	149
Cardiac Surgery	21
Cardio-Thoracic Surgery	18
Cardio-Vascular & Thoracic Surgery	52
Cardio-Vascular Surgery	49
Dermatology	50
Emergency Medicine	126
Family Practice	358
Gastroenterology	23
General Practice	237
General Surgery	467
Geriatrics	1
Gynecology	20
Hematology	1
Hematology/Oncology	7
Industrial Medicine	5
Infectious Diseases	1
Internal Medicine	732
Nephrology	1
Neurology	70
Neurosurgery	120
Nuclear Medicine	1
OB/GYN	532
Oncology	3
Ophthalmology	141
Orthopedics	6
Orthopedic Surgery	394
Other	1
Otolaryngology	80
Pathology	22
Pediatrics	204
Plastic Surgery	116
Preventive Medicine	1
Proctology	6
Psychiatry	31
Pulmonary Diseases	1
Radiology	277
Rehab/Physiatry	58
Rheumatology	6
Surgical Technician	2
Thoracic Surgery	19
Urology	76
Vascular Surgery	10
Vascular and Thoracic Surgery	7
Not Otherwise Classified	28
Corporate Liability	659
Partnership Liability	35
Nurse Anesthetist	10
Nurse Midwives	0
Nurse Practitioner	2
Physiotherapist	1
Physician's Assistant	4
Registered Nurse	3
X-Ray Technician	1
TOTAL	**5,387**

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TABLE 3

Number of claims and suits (C & S) filed by specialty—July 1, 1987-June 30, 1992*

Specialty	# Open C & S	Closed Claims (Except Verdicts) No Loss Pmt # C & S	Closed Claims (Except Verdicts) No Loss Pmt Avg Exp Pmt	Closed Verdicts** No Loss Payment # C & S	Closed Verdicts** No Loss Payment Avg Exp Pmt	Closed Settlements w/ Loss Pmt. # C & S	Closed Settlements w/ Loss Pmt. Avg Loss Pmt	Closed Settlements w/ Loss Pmt. Avg Exp Pmt	Closed Verdicts** w/ Loss Pmt. # C & S	Closed Verdicts** w/ Loss Pmt. Avg Loss Pmt	Closed Verdicts** w/ Loss Pmt. Avg Exp Pmt
Allergy	[illegible]	0	$ -0-	0	-0-	0	$ -0-	$ -0-	0	-0-	$ -0-
Anesthesiology	53	44	2,944	3	$17,744	33	34,386	1,888	1	200,000	19,470
Cardiac Surgery	15	6	2,525	0	-0-	0	-0-	-0-	0	-0-	-0-
Cardio-Thoracic Surg.	12	6	2,873	0	-0-	0	-0-	-0-	0	-0-	-0-
Cardio-Vasc. Surg.	25	12	4,196	3	21,047	8	81,875	11,616	1	100,000	34,471
Cardio-Vascular & Thoracic Surgery	39	9	2,692	0	-0-	4	75,625	14,123	0	-0-	-0-
Cardiology	102	43	4,960	0	-0-	4	113,188	9,628	0	-0-	-0-
Colon-Rectal Surgery	0	0	-0-	0	-0-	0	-0-	-0-	0	-0-	-0-
Dermatology	22	25	2,268	0	-0-	3	18,667	167	0	-0-	-0-
Emergency Medicine	72	37	3,802	3	20,926	12	94,179	10,606	2	48,750	10,594
Family Practice	208	104	3,527	5	25,978	40	103,547	7,257	1	3,600	4,350
Gastroenterology	15	7	2,931	0	-0-	1	52,500	558	0	-0-	-0-
General Practice	124	62	3,334	10	40,951	39	80,049	9,411	2	52,025	25,922
General Surgery	257	125	3,815	13	25,364	72	87,159	8,504	0	-0-	-0-
Geriatrics	0	1	8,658	0	-0-	0	-0-	-0-	0	-0-	-0-
Gynecology	[illegible]	5	3,289	0	-0-	7	97,857	4,144	0	-0-	-0-
Hematology	1	0	-0-	0	-0-	0	-0-	-0-	0	-0-	-0-
Hematology/Oncology	6	1	577	0	-0-	0	-0-	-0-	0	-0-	-0-
Industrial Medicine	2	1	9,794	0	-0-	1	130,000	699	1	4,000	5,241
Infectious Diseases	1	0	-0-	0	-0-	0	-0-	-0-	0	-0-	-0-
Internal Medicine	435	217	3,759	11	22,778	67	106,514	9,114	2	76,252	27,559
Nephrology	1	0	-0-	0	-0-	0	-0-	-0-	0	-0-	-0-
Neurology	37	28	4,955	2	20,716	3	16,500	4,919	0	-0-	-0-
Neurosurgery	55	50	6,717	4	6,101	9	78,741	11,659	2	100,000	17,955
Nuclear Medicine	1	0	-0-	0	-0-	0	-0-	-0-	0	-0-	-0-
OB/GYN	305	141	3,968	[illegible]	25,122	74	105,435	9,210	4	85,398	25,436
Oncology	3	0	-0-	0	-0-	0	-0-	-0-	0	-0-	-0-
Ophthalmology	82	43	2,692	4	7,054	12	83,406	6,191	0	-0-	-0-
Orthopedics	1	5	3,682	0	-0-	0	-0-	-0-	0	-0-	-0-
Orthopedic Surgery	188	143	3,484	11	22,257	51	86,042	7,592	1	127,500	15,175
Otolaryngology	37	35	3,881	1	3,936	6	33,672	4,590	1	1,200	21,640
Pathology	19	2	12,804	0	-0-	1	70,000	10,104	0	-0-	-0-
Pediatrics	131	52	6,461	4	23,478	17	97,368	9,007	0	-0-	-0-
Plastic Surgery	75	30	1,970	1	11,846	9	61,328	9,542	1	3,803	18,586
Preventive Medicine	0	1	21,584	0	-0-	0	-0-	-0-	0	-0-	-0-
Proctology	0	0	-0-	0	-0-	6	131,667	14,934	0	-0-	-0-
Psychiatry	18	[illegible]	4,452	2	22.965	3	16,767	12,091	0	-0-	-0-
Pulmonary Diseases	0	1	1,571	0	-0-	0	-0-	-0-	0	-0-	-0-
Radiology	173	79	4,337	1	14,338	22	96,002	9,256	2	93,290	19,157
Rehab/Physiatry	43	15	4,419	0	-0-	0	-0-	-0-	0	-0-	-0-
Rheumatology	5	1	8,485	0	-0-	0	-0-	-0-	0	-0-	-0-
Thoracic Surgery	9	7	7,275	0	-0-	3	71,500	5,118	0	-0-	-0-
Urology	45	22	4,173	1	16,960	[illegible]	81,672	8,748	0	-0-	-0-
Vascular Surgery	7	3	3,812	0	-0-	0	-0-	-0-	0	-0-	-0-
Vasc. & Thoracic Srg.	4	3	1,870	0	-0-	0	-0-	-0-	0	-0-	-0-
Not Oth. Classified	15	7	1,658	1	3,076	4	23,750	7,349	1	162,784	21,351
Physician's Assistant	3	1	1,425	0	-0-	0	-0-	-0-	0	-0-	-0-
Registered Nurse	2	0	-0-	0	-0-	1	7,500	134	0	-0-	-0-
Physiotherapist	0	0	-0-	0	-0-	1	5,000	-0-	0	-0-	-0-
Nurse Anesthetist	1	4	1,669	0	-0-	5	18,979	1,610	0	-0-	-0-
Nurse Midwife	0	0	-0-	0	-0-	0	-0-	-0-	0	-0-	-0-
Nurse Practitioner	1	0	-0-	1	6,265	0	-0-	-0-	0	-0-	-0-
Surgical Technician	1	1	6,813	0	-0-	0	-0-	-0-	0	-0-	-0-
X-ray Technician	0	1	1,484	0	-0-	0	-0-	-0-	0	-0-	-0-
Other	1	0	-0-	0	-0-	0	-0-	-0-	0	-0-	-0-
Corporate Liability	490	128	4,511	18	15,246	21	104,836	8,373	2	137,500	14,172
Partnership Liability	29	6	6,457	0	-0-	0	-0-	-0-	0	-0-	-0-
GRAND TOTALS	**3,187**	**1,522**	**$3,990**	**107**	**$21,583**	**547**	**$87,618**	**$ 8,147**	**24**	**$ 81,671**	**$19,698**

* Claims and suits filed during this period resulted from policy years 1978-1988. PMSLIC's limit of liability is $100,000 per incident for policy years 1978-1982, $150,000 for 1983 and $200,000 for 1984-1991.

** Cases tried to verdict which are still open pending final resolution due to post trial motions, appeals, etc. are counted as open files.

PENN STATE GRADUATES BEGIN RESIDENCIES

Graduates of Penn State's College of Medicine at The Milton S. Hershey Medical Center, Hershey, began residency programs in 19 areas of medical practice in July.

Consistent with last year, nearly 50 percent of the graduating class will work in primary care fields, with the largest number pursuing family and community medicine residencies.

Forty-three of the 93 graduates will pursue residencies in primary care. Thirteen graduates will pursue family and community medicine, 12—pediatrics, 11—internal medicine, and seven—obstetrics/gynecology.

Meanwhile, 50 graduates will pursue residencies in specialty fields. Approximately 55 percent of the graduates will remain in Pennsylvania for their residencies.

CORRECTION

In the Medical Abstracts section of the July 1992 issue of PENNSYLVANIA MEDICINE, the byline for the "Clinical Use of Ambulatory Blood Pressure Recording: Value in Patient Care" abstract incorrectly identifies the first author as *Alan* P. Shapiro, MD. Dr. Shapiro's first name is *Alvin*.

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NEWSMAKERS

Mark W. Shulkin, MD, Media psychiatrist, has been installed as president of the Delaware County Medical Society.

Thomas L. Kennedy, MD, residency director, Geisinger Medical Center, Danville, was elected president of the Pennsylvania Academy of Otolaryngology—Head and Neck Surgery. **Frank I. Marlowe, MD,** chief of otolaryngology, Medical College of Pennsylvania and Presbyterian Medical Center, Philadelphia, was elected president elect.

Hershey physician **Joseph W. Sassani, MD,** was elected president of the Pennsylvania Academy of Ophthalmology at its annual scientific meeting in July.



Dr. Sassani

Mia C. Bartuska, MD, a 1992 graduate of the Medical College of Pennsylvania, is an intern in family practice at Harrisburg Hospital. She is the daughter of **Doris G. Bartuska, MD,** Philadelphia.

Two members of the University of Pennsylvania Medical Center's Department of Dermatology—**Gerald S. Lazarus, MD,** chairman, and **Edward Bondi, MD,** associate professor—were recognized by the school of medicine class of 1992 for excellence in teaching.

Michael J. Moritz, MD, associate professor of surgery and acting director, Division of Transplantation, Thomas Jefferson University Hospital, has been named chief of the Section of Liver Transplantation in Jefferson's Department of Surgery.

Myron Yanoff, MD, chairman and professor of the Department of Ophthalmology, Hahnemann University School of Medicine, Philadelphia, was invited as visiting professor to the world-famous faculty of medicine of the University of Vienna, Austria. During his visit this month, Dr. Yanoff will conduct lectures and hold seminars on various current aspects of ophthalmology, surgery, and research for the prevention of blindness.

The Medical College of Pennsylvania (MCP) has dedicated the Alma Dea Marani, MD, Chair in Surgery in honor of the internationally known plastic surgeon and accomplished sculptor best known for her role in bringing art into the college's curriculum. This year's recipient is **Joel J. Roslyn, MD,** who joined MCP as chairman, Department of Surgery.

Scott D. Goldstein, MD, a member of the surgery staff at Pennsylvania Hospital in Philadelphia for seven years, has been named chief of the hospital's Section on Colon-Rectal Surgery, Department of Surgery. Dr. Goldstein also serves as assistant professor of surgery at Jefferson Medical College and is a clinical associate professor in surgery at the University of Pennsylvania School of Medicine.

Two University of Pennsylvania Medical Center physicians were honored by the Philadelphia Psychiatric Society: **Harold I. Lief, MD,** received the society's Lifetime Achievement Award in recognition of his career activities which advanced psychiatry in patient care, teaching, and research; and **Kenneth D. Cohen, MD,** was named Practitioner of the Year in recognition of his outstanding character, dedication, and committment to patient care.

Ajit K. Sachdeva, MD, associate professor of surgery, Medical College of Pennsylvania, was installed as the twelfth president of the Association for Surgical Education during its annual meeting in Canada.

David Nash, MD, director of health policy and clinical outcomes, Thomas Jefferson University Hospital, has been appointed to the Users Advisory Group of the Joint Commission on Accreditation of Healthcare Organizations.

Paul B. Gilman, MD, a member of the medical staff in the Divisions of Hematology and Oncology, Lankenau Hospital, Wynnewood, has been appointed to the Lower Merion board of directors of the American Cancer Society.

John C. Cutler, MD, MPH, public health specialist, Pittsburgh, received the National Family Planning Reproductive Health Association's International Award for his leadership in improving access to family planning.

Mark G. Graham, MD, FACP, FACOEM, a member of the Division of Environmental Medicine and Toxicology, Jefferson College, and medical director, the Philadelphia Comprehensive Occupational Medical Program, was elected president of the Philadelphia Occupational and Environmental Medical Society for a two-year term.

Stephen C. Silver, MD, chief of service, Colon and Rectal Section, Department of Surgery, Delaware County Memorial Hospital, Drexel Hill, has been elected president elect of the Pennsylvania Society of Colon and Rectal Surgeons.



Democratic presidential candidate Bill Clinton (third from left) and United States Senator Harris Wofford (D-PA, far right) visited the Intensive Care Nursery at Pennsylvania Hospital, Philadelphia, during a recent campaign stop. Jeffrey Gerdes, MD (second from right), neonatologist, Section on Newborn Pediatrics, Pennsylvania Hospital, looks on. After a tour of the facility, Governor Clinton discussed his plans for national health care with a press corps on the front steps of the hospital.



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Solomon L. Balin, *West Chester*
Hahnemann University School of Medicine, 1943; age 83, died May 27, 1992. Dr. Balin was a general practitioner.•

Solomon Disick, *State College*
Medical College of Virginia School of Medicine, 1935; age 80, died May 17, 1992. Dr. Disick was a clinical pharmacologist.•

Stuart W. Dittmar, *Chambersburg*
Graduated 1960; age 81, died April 25, 1992. Dr. Dittmar was a general practitioner.•

Michael O. Grassi, *Glenmoore*
Georgetown University School of Medicine, 1938; age 79, died June 2, 1992. Dr. Grassi was a psychiatrist.•

Leonard N. Horowitz, *Philadelphia*
University of Pennsylvania School of Medicine, 1972; age 44, died May 21, 1992. Dr. Horowitz was a cardiologist.•

Robert H. Israel, *Asheville, NC*
Graduated 1923; age 91, died April 11, 1992. Dr. Israel was a psychiatrist.•

John H. Kupp, *Allentown*
Johns Hopkins University School of Medicine, 1928; age 90. Dr. Kupp was an ophthalmologist.•

Ewart G. McGruder, *Bristol*
Graduated 1939; age 77, died April 5, 1992. Dr. McGruder was a general practitioner.•

Mildred C. Pfeiffer, *Wyndmoor*
University of Pennsylvania School of Medicine, 1936; age 81, died June 23, 1992. Dr. Pfeiffer was an internist.•

Daniel Spiegel, *McKeesport*
Universitaire Katholique de Louvain, faculte de Medicine, Louvain, Belgium, 1960; age 57, died May 15, 1992. Dr. Spiegel was an obstetrician and gynecologist.•

Maurice Attie, *Bala Cynwyd*
University of Washington School of Medicine, 1975, died April 5, 1992. Dr. Attie was an endocrinologist.

William G. Best, *Glen Mills*
Georgetown University School of Medicine, 1941; age 78, died April 21, 1992. Dr. Best was a pathologist.

Albert V. Corrado, *Pittsburgh*
University of Pittsburgh School of Medicine, 1948; age 68, died May 6, 1992. Dr. Corrado was a psychologist.

Francis G. Harrison Jr., *Bryn Mawr*
Syracuse University, 1944; age 73, died May 8, 1992. Dr. Harrison was an internist and urologist.

Guy W. McLaughlin, *Philadelphia*
Jefferson Medical College, 1959; age 63, died May 24, 1992. Dr. McLaughlin was a pediatrician.

Howard T. Meminger, *Fayetteville*
Philadelphia College of Osteopathic Medicine; age 76, died May 2, 1992. Dr. Meminger was an ophthalmologist.

James Shaffer, *Orangeville, OH*
Philadelphia College of Osteopathic Medicine, 1986; age 47, died April 18, 1992. Dr. Shaffer was a general practitioner.

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Future Possibilities

Lynn Michele Lucas-Fehm, MD

Editor's note: This article is excerpted from Dr. Lucas-Fehm's presentation at "Diversity: A Workshop for the Future Leaders of Medicine," held during the Society's 1992 Leadership Conference.

In my personal experience, the future holds exceedingly different possibilities for young physicians versus female physicians versus minority physicians. For young physicians, the upcoming years are uncertain with the inevidability of massive changes in the health care delivery system in this country. We cannot turn on the news without hearing about the health care crisis, and it is almost impossible to keep up with the numerous reform plans being proposed almost daily.

As a female physician, I'm filled with optimism. Our ability to contribute to and positively influence the profession grows. Sure, there are problems; and indeed, inequities still exist. Yet, at the same time, an AMA report reveals that [the numbers of] female physicians increased at a rate almost four times as great as [that of] male physicians. If for no other reason, changes will occur because of our vastly increasing numbers.

However, when I turn my attention to the future for black and Hispanic physicians, the optimism I proudly display about the future for women is brought back down to earth by a healthy dose of reality. Despite the fact that both the black and Hispanic segments of our nation's population are growing at a faster rate than is the white segment, the number of minority students enrolling in medical school has been static for 10 years. The logical question is, "Why?"

While I have no intention of turning this into a sociological or philosophical discussion, I would like to relay some personal experiences I've had in speaking to Philadelphia's inner-city, public school students. At some point during the dialogue, I cannot help but ask, "How many of you have considered becoming a doctor?" I must sadly report that I've often seen no one put up a hand. I am then compelled to ask why no one is interested in the medical profession. Typical answers are, "Medical school is too expensive and takes too long," and "Scholarships are no longer available." Other students claim they are going to "make it" on sports scholarships and hope to become professional athletes.

As I said, this is no time for a sociology lecture; but it may be time for us as a profession to look at ourselves and determine whether or not the decision of these students not to *even consider* entering medicine is not only a loss to them, but also to the medical profession. On a greater scale, it may even be our nation's loss.

I recently contacted the AMA for statistics on minorities entering medicine, as well as where minority physicians go to practice upon completion of their training. I was sent a copy of a *New England Journal of Medicine* article which tracked minority graduates from U. S. medical schools to determine where they eventually practiced. The study showed that a larger portion of minority graduates chose primary care specialities, which government surveys show are desperately in need of more physicians. In addition the study showed that significantly more minority physicians practiced in locations designated as Health Manpower Shortage Areas by the federal government.

If the study is indeed correct, and if we accept that it is our humanitarian mission as healers to put forth our best effort and serve everyone in our nation, then the low number of minority students enrolled in medical school is not something we can afford to ignore or tolerate.

Despite the harsh realities of the above, I am still optimistic. Medicine has been, and will remain for me, the finest profession anyone can choose. For the profession's and future nation's well-being, though, all physicians must commit to assuring that opportunities exist for individuals from all socioeconomic backgrounds to join and contribute to medicine. In so doing, we will all benefit and better serve our patients.



Dr. Lucas-Fehm, a Philadelphia radiologist, was on the board of the Philadelphia County Medical Society and was chair of its Young Physician Section during 1991-92.



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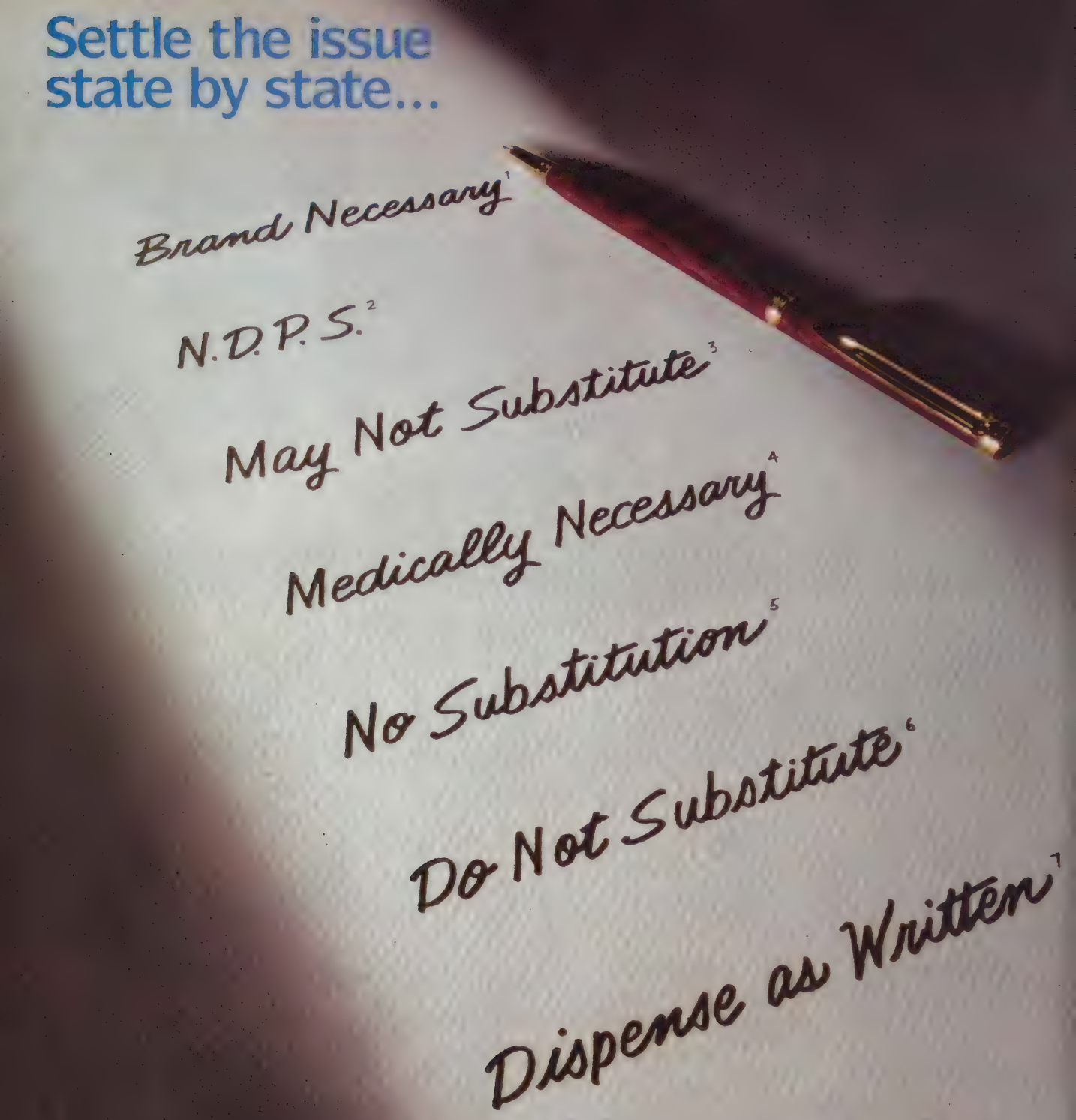
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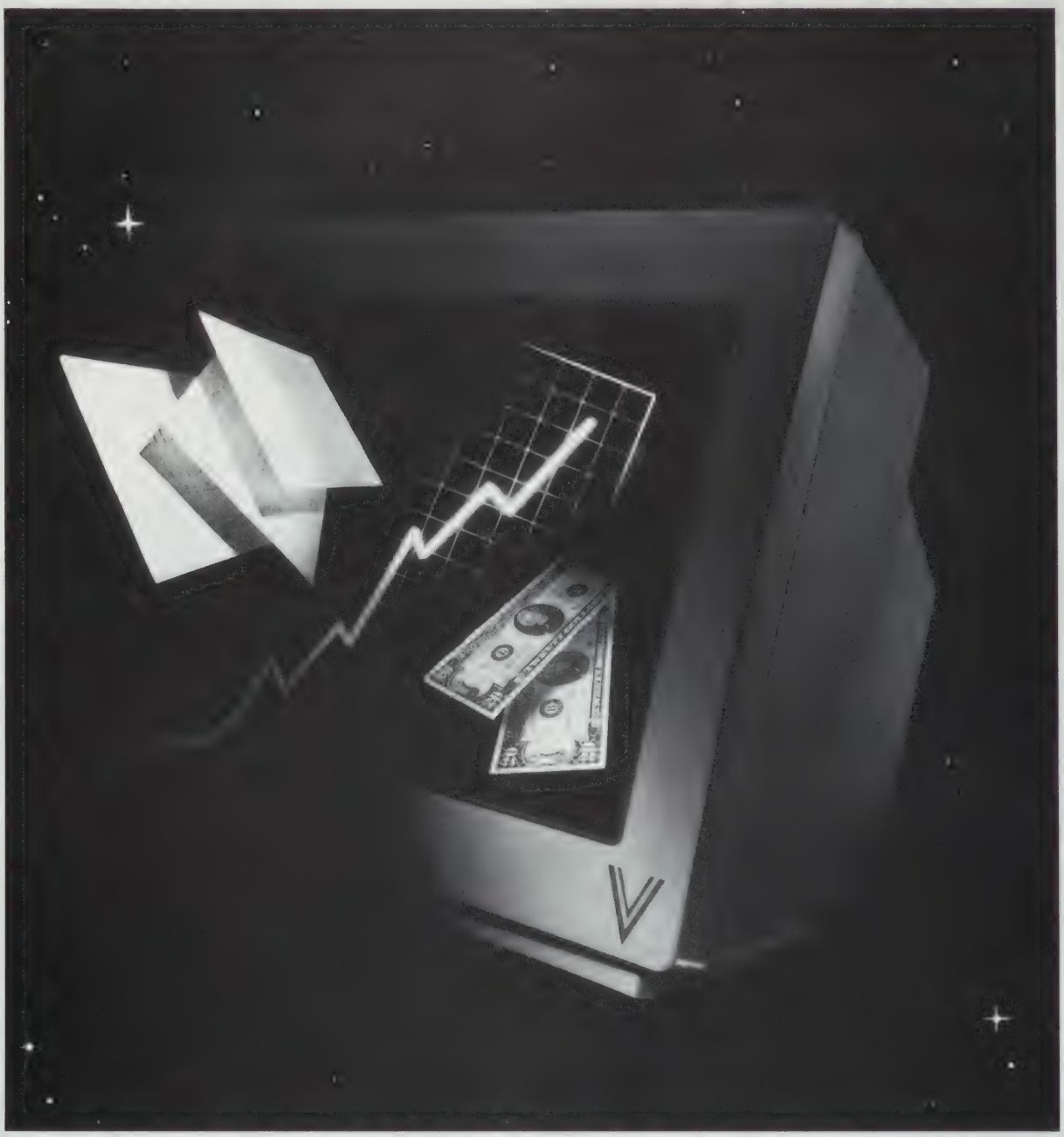
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Donald G. Ferguson, MD

143rd President of the Pennsylvania Medical Society

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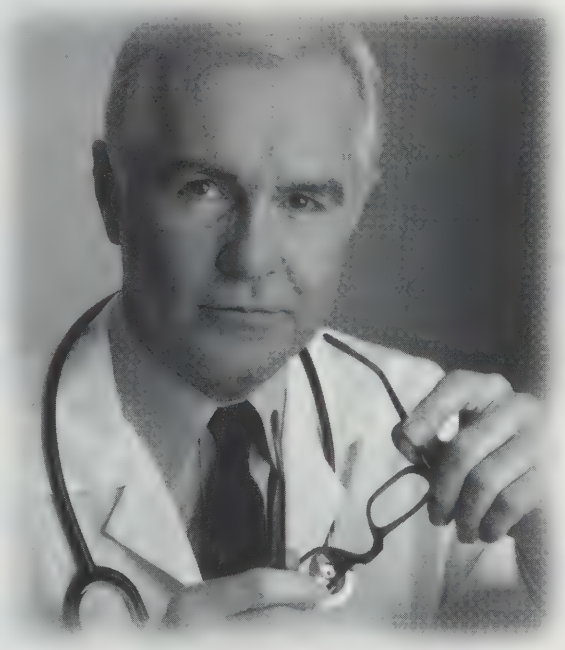
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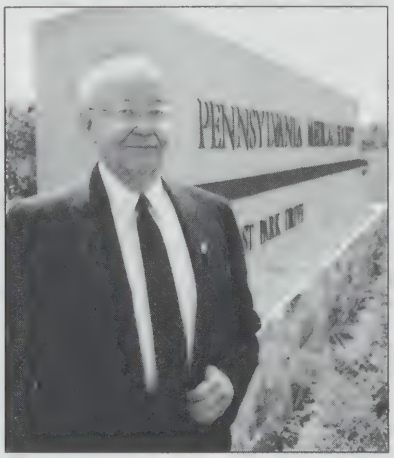
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Cover photo by John Maietta, Harrisburg

Health Care Reform

Health care reform has quickly become one of the nation's most talked about subjects. Politicians and other groups are scrambling to develop a system suitable for America from various alternatives. Yet, the reform may require even more, including careful study of other health care systems and perspectives from the physicians working within them.

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PENNSYLVANIA MEDICINE (ISSN 0031-4595) is published monthly by the Pennsylvania Medical Society, 777 East Park Drive, Harrisburg, PA 17111.
SUBSCRIPTIONS: $20 per year— United States and Canada; $30—all others. Single issues $3.00 per copy prepaid; special issues cost more.
POSTMASTER: Send address changes to PENNSYLVANIA MEDICINE, 777 East Park Drive, PO Box 8820, Harrisburg, PA 17105–8820. Second class postage paid at Harrisburg, PA 17105.



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SOCIETY OPPOSING RULES COMMITTEE CHANGES TO WORKERS' COMP: The State Society is strongly opposing House Rules Committee amendments to House Bill 2140 addressing workers' compensation. The amendments, approved September 23, reduce the cap on medical fees to 117 percent of Medicare, remove the annual update, provide a permanent tie to Medicare, and remove provisions allowing the negotiation of fees. At press time, the governor had called a special session of the legislature for October 5 to address the issue.

IRRC APPROVES GENERAL ASSISTANCE CUTS: Despite opposition from the Society and other health care providers, patients, and consumer advocates, the Independent Regulatory Review Commission (IRRC) on September 2 accepted as approved the governor's proposal to control welfare costs by cutting medical and dental benefits through the state's General Assistance program. IRRC notified the House Health and Welfare Committee of its decision on September 21. At press time, the committee, which originally opposed the proposal, was considering reporting a concurrent resolution calling for disapproval of the regulations.

RURAL HEALTH CARE BILL PASSED: The House of Representatives on September 23 unanimously passed House Bill 1633, which addresses rural and inner-city health care issues. Supported by the Society, the bill encourages health care professionals to practice in medically underserved areas. Specifically, it establishes a health care professional school and loan fund in the Pennsylvania Higher Education Assistance Agency.

SOCIETY SUPPORTING "YOUTH AGAINST TOBACCO:" The Society is joining the Departments of Health and Education as a partner in "Youth Against Tobacco," an on-going project aimed at reducing tobacco usage among teenagers. The three groups are planning a series of activities throughout the current school year, including a promotion in conjunction with the Great American Smokeout in November. For information call the Society's Department of Public Affairs at 1-800-228-7823.

AUXILIARY DONATES $5,850 TO AID HURRICANE VICTIMS: The Pennsylvania Medical Society Auxiliary to date has donated $5,850 to aid victims of hurricanes Andrew and Iniki. The money was distributed in consultation and cooperation with Florida and Hawaii medical auxiliaries. Physicians and county societies wishing to make donations may do so by sending a check payable to: The Educational and Scientific Trust, Pennsylvania Medical Society. Please specify that the donation is for the Auxiliary Emergency Assistance Fund.

SOCIETY, AGING JOIN TO BATTLE DEPRESSION IN THE ELDERLY: Society President Robert N. Moyers, MD, and Secretary of Aging Linda M. Rhodes in late summer announced a joint effort to improve the diagnosis and treatment of depression in the elderly. The Educational and Scientific Trust, on behalf of the Society, kicked off the program by sending surveys to 3,000 physicians in the state to determine their awareness of and treatment methods for depression in the elderly. Focus groups of physicians were also conducted by the Trust in September. A comprehensive report is expected later this month.

57 RESOLUTIONS RECEIVED FOR HOUSE OF DELEGATES: The October issue of the Society's *Executive Report* included summaries of the 57 resolutions submitted for the October 23-25 meeting of the House of Delegates in Philadelphia. Resolutions address AIDS/HIV issues, health care reform, tort reform, generic drugs, family violence, and a number of other important issues. Also, a special forum on health care reform will be held Friday evening. Coverage of the annual meeting will be published in the December issue of PENNSYLVANIA MEDICINE.

PENNSYLVANIA MEDICINE

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Who's Setting Your Priorities?

John W. Mills, MD
Medical Editor

"Let's have some direction from the membership and delegates—and, unlike the public, if we feel it's important, let's ante up..."

At least once during my relatively brief stint as medical editor of this magazine, I've alluded to my own financial dilemma brought on by a number of circumstances in the OB/GYN specialty. Perhaps I was a victim of the changing face of medicine. Certainly the malpractice crisis of the late '70s was a major contributing factor coupled with the wild inflation of the early '80s.

I only mention this to set the stage, if you will, for this month's editorial, for I sense that the Pennsylvania Medical Society also finds itself in the midst of enormous economic pressures as it tries to deal with the complex issues facing health care in Pennsylvania.

The public and the legislature seem intent on controlling the practice of medicine statewide, and Congress is no slouch either in promulgating, through the Health Care Financing Administration (HCFA), ever more ominous "R&R" (Rules and Regulations in this case) for us to obey as we attempt to diagnose and treat older and sicker patients.

When budgets are tight, we must scrutinize them even more closely as we try to allocate decreasing funds to increasing costs. Meanwhile, the State Society is caught up in a legal maelstrom—spending large sums of money for legal expertise and waging our battles with government—frequently for naught.

Why do we do this? The answer simply is because our members expect us to. But, once the process is begun, many of these same members don't want to compromise—they want it "their way"—period. I really don't feel that the average Society member has any concept of the time and effort that goes into all these battles, along with the enormous sums of money. I submit that we may be digging our own financial grave.

We simply don't have the wherewithal to do "all" for all our members. Your board, between House of Delegates' meetings, spends countless hours debating our stances and our courses of action, and your staff at the Society does yeomen's service in carrying out those mandates.

To balance a budget weighted by these herculean legislative and regulatory affairs, the Society's Finance Committee has directed a very serious review of the proposed expenditures for 1993 and may cut some items.

Even though PENNSYLVANIA MEDICINE has won two awards in the past year—one national and one regional—for its new look and contents, it continues to lose money because advertising is down—a nationwide trend. Thus, your publication is one of the items that may be scaled back or eliminated.

My personal reaction to this is negative, and I'm not paid for my work at PENNSYLVANIA MEDICINE, so I have no financial ax to grind here. I feel it would be a serious mistake to limit or cut the primary regular means of communication the Society has with you—our members. It is a tangible return for our dues which strives to keep us all informed.

As a freshman trustee, I'm probably still wet behind the ears, but I truly believe the House of Delegates needs to address the Society's course over the rest of the decade so that we don't go broke trying to do the impossible. Let's have some direction from the membership and delegates—and, unlike the public, if we feel it's important, let's ante up and be willing to pay for it with increased dues.

Our primary focus should be good, humane medicine. We should attempt to practice the best medicine we are capable of with humility, despite the adversarial circumstances. That's the way you win public support, not by publicity campaigns!

Don't sweat the small stuff.

Perhaps most of our "tilting at windmills" is small stuff, after all.



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The Shortest Year

Robert N. Moyers, MD



Thinking back over my year as president is a bit like trying to remember all of the stops on a nine-cities-in-six-days vacation. I've covered a lot of ground, and I am more aware than ever of the boldness of our enterprise. Our profession and our state are both impressively large, diverse, and influential.

My goal, the same as that of our predecessors since 1846, has been to ensure physicians a place at the table where policies are being formulated. I have seized every opportunity to make the physician's voice heard above the general cacophony in public discourse. Together with other Society leaders, I have refused to allow our patients and their concerns to be ignored in the current debates that all too often start and end at cost control without considering the questions of access and quality. And thanks to the efforts of Society leadership and staff, we have had successes in many arenas.

I had the opportunity to turn the spotlight on our most critical concerns before congressional and state legislative hearings on health care reform and other matters in Washington, Harrisburg, Hershey, Pittsburgh, and Erie. Meetings with Vice President Dan Quayle, Presidential advisor Gail Wilensky, Senators Arlen Specter and Harris Wofford, and numerous congressional representatives served as occasions to bring the insights of Pennsylvania physicians to the national forum.

Within the state, we are continuing to strengthen our already well-regarded governmental presence as we deal with indigent care, auto insurance, workers' compensation, and tort reform.

The Society is now a member of a health care reform study group, convened by Representative Dwight Evans (D-Philadelphia), supported by the Pennsylvania Business Roundtable and including representatives from health care, insurance, and business.

We made it a point to involve ourselves in Governor Casey's Economic Development Partnership, even though the governor did not see fit to include physicians or other health care professionals in this group charged with creating the "ideal" health plan for Pennsylvania. We had representatives at every meeting, and we voiced our view of problems in the current system and identified serious flaws in the partnership's proposal for a mandated single-payer system.

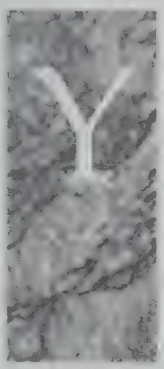
Physician input in the public arena is not only desirable but absolutely necessary. This is true in many, many legislative and regulatory matters, but it has never been more critical than in the current and future debate over health care reform.

We are the advocates for our patients, and we derive much of our professional credibility from that role. We must also be strong advocates for our professionalism and guard against allowing ourselves to become mere pawns, i.e, "providers," in managed care systems created and controlled by others.

Our organizational strength will be crucial in the months and years ahead, as we represent our members and our patients in the restructuring of the health care system.

Our own Long Range Assessment Committee is developing a Pennsylvania Medical Society proposal for health care reform that we believe will gain physicians a prominent seat at the table as the debate goes on.

It has been a busy, challenging year, as I have tried to carry the message and mission of the Pennsylvania Medical Society to all who offered me the opportunity. My experiences served only to reinforce my respect for you—my honorable, hard-working, dedicated colleagues—and my commitment to unity. I am proud to be a member of this profession. Thank you for giving me the honor of serving as your president.



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REACTING TO ACT 6

Editor's Note: The following is excerpted from a letter written by the physicians at Cumberland Valley Neurosurgical Consultants (CVNC), Chambersburg. The letter was originally sent to all Pennsylvania neurosurgeons and CVNC referring physicians, as well as other select legislators and individuals in the state.

It is with intense regret that we must inform you that Cumberland Valley Neurosurgical Consultants (CVNC) will no longer accept referrals of patients whose medical care is covered by automobile insurance except in true medical emergencies. This action is necessitated by the provisions of Act 6 of Pennsylvania law, which we hold is discriminatory, unethical, unfair, and restrictive to any reasonable standard of medical practice. We want to make it very clear that we will, of course, respond and provide care for cases where we are called to the Emergency Department or otherwise asked to see patients with medically emergent conditions. For non-emergent situations, however, we must ask that you refer patients elsewhere, preferably to a trauma center, where Act 6 provides for payment of the full reasonable fee schedule for automobile insurance covered care.

CVNC has been very fortunate to have our practice grow to the point that we must cut back on some services provided. Whereas we would like to provide full services, including services for automobile insurance patients, we do not have the manpower sufficient to do so. We have been trying for several months to recruit an additional neurosurgeon and an additional neurologist to join us, but the unfavorable environment for medical practice in Pennsylvania resulting from Act 6 in large part, as well as legislation preventing balance billing for Medicare services and the pending legislation tying workers' compensation to Medicare, has made it impossible to attract a thoughtful physician to join us....

To make it clear that the decision not to see patients under the provisions of Act 6 is not monetarily driven, we point out that we will still be pleased to see Medicare patients, Medical Assistance patients, and pro-bono patients, all of which pay less that Act 6 provides. Clearly, then, it is not the pecuniary aspect alone but the principle of the situation that compels us to cease seeing Act 6 patients. We hold that at best, Act 6 is discriminatory, unfair, ill-founded, and counterproductive to a reasonable standard of medical practice...We will not, we cannot, in good conscience, participate in such an ill-founded plan which, if allowed to continue, will lead to a deplorable degradation of medical care in this commonwealth.

Whereas physicians as a profession have recognized their responsibility to make a great contribution to the medical care of the elderly and have demonstrated their acceptance of this responsibility by caring for Medicare patients at a reduction in cost for this care to nearly one-half of the usual, reasonable cost, the profession cannot extend this reduction to automobile accident patients, workers' compensation patients, and on and on. Whereas the elderly cannot, in many cases, earn the required funds to pay for their medical care, people who desire the privilege of driving automobiles should be required to take responsibility for the reasonable cost of their medical care resulting from driving automobiles...To require physicians to pay a disproportionate amount of the cost of this care, as Act 6 does, is to teach abandonment of personal responsibility for each and every driver of an automobile in this Commonwealth...Our cessation of providing care for patients under Act 6 is our vote against abrogation of personal responsibility....

"We must react, [and] our cessation of seeing Act 6 patients is our first step in this reaction. What will be second? Workers' compensation?"

We have heard several different politicians say that they are not aware of any case of more difficult access to medical care because of Act 6. We have heard them say that they felt comfortable about putting workers' compensation care under the same type of coverage, because physicians had not reacted adversely to Act 6....

We don't want to be politically active, to have to react against ill-founded, harmful legislation. We'd like to practice medicine, to thrive on the gratitude of our patients and spend any time left over in upgrading our skills and knowledge. But the deplorable performance of our politicians has now made this impossible. We must react, [and] our cessation of seeing Act 6 patients is our first step in this reaction. What will be second? Workers' compensation?

Cost analyses demonstrate that the parasitic administrative cost of medical care is more than twice, and some analyses would indicate even three or four times the cost of physicians in providing medical care—and this does *not* include the administrative cost within the physician's office forced upon the physician by insurance companies, lawyers, and government. Cost analysis of physicians' practice overhead shows it to be in the 40 to 45 percent range. The physicians cannot make this cost go away, no matter how hard he/she might try. It is there, and it is steadily rising.

From talking with politicians, it is very clear that they have no concept at all that if you cut back a physician's fees by 40 percent, you cut his/her income by two-thirds, since the cut in fees must be taken from the 60 percent of office revenue left after overhead—it obviously cannot come out of the overhead....

If our legislators were really interested in solutions to the crisis in the cost of medical care, they would demonstrate some ingenuity in attacking the parasitic waste cost of medicine, rather than attacking the physician providers of medical care, whose cost pales in comparison to the cost of the parasitic administrative waste perpetuated by the insurance companies, the legal system, and the government....

When we started the practice of neurosurgery in Chambersburg, Pennsylvania could equal any state in the union in providing a favorable environment for the practice of medicine. Since then, our governor and politicians, devoid of any spark of originality, inventiveness, or reason, have only been able to copy from the example set by Dukakis' Massachusetts by enacting the Medicare balance billing law [and] Act 6, and now they are pushing towards a similar debacle with

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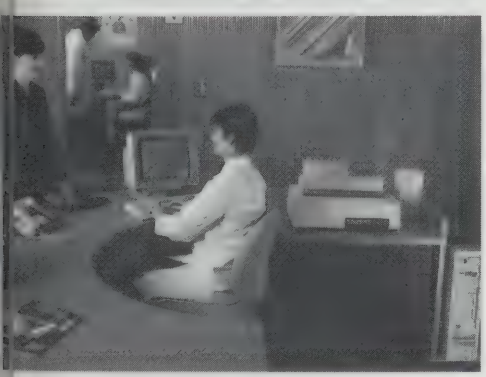
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workers' compensation. If this comes to pass, then we submit that the Commonwealth of Pennsylvania will have become at least tied (with Massachusetts and West Virginia) for the worst environment in which to practice medicine in these United States.

"As ye sow, so shall ye reap." The harvest, in this case, we fear, will be the loss of good physicians engaged in a reasonable standard of practice in this commonwealth. By ceasing to see Act 6 patients at this time, Cumberland Valley Neurological Consultants is trying to do what little it can to prevent this bitter harvest.

C.B. Early, MD
J.W. Laing, MD
V.G. Schorn, MD
S.E. Sollenberger, DO
Cumberland Valley Neurological Consultants, Chambersburg

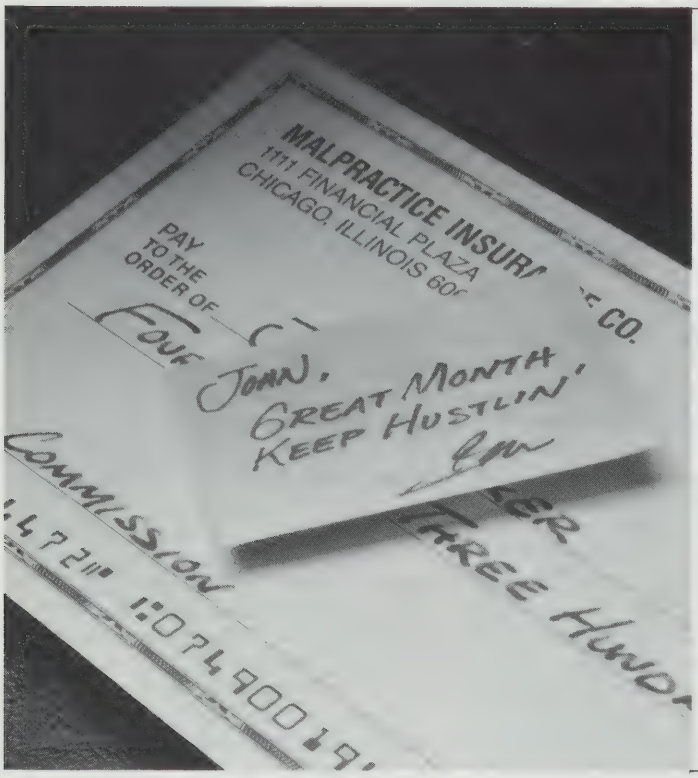
SPEAKING OUT ABOUT THE HEALTH CARE CRISIS

Editor's Note: The following Letter to the Editor is reprinted with permission from the September 1992 issue of Consumer Reports. *It was written by the State Society's president in response to the article, "Wasted Health Care Dollars," which was published in the July 1992 issue of* Consumer Reports.

"Physicians want meaningful reform, but they fear a "new" plan that merely trades one problem, such as the uninsured, for another, such as strict bureaucratic rationing of health care."

The U.S. can't afford continued health care inflation. But neither can we afford to be misled about the causes. Technology certainly has added to costs, but who wants to forgo those options when they or a loved one is a patient? Your report also ignored social problems as a major cause of massive increases in health care demand. The U.S. has higher per-capita rates of AIDS, violence, accidents, smoking, drinking, substance abuse, sexually transmitted disease, and poverty than do most nations. You cite high U.S. infant mortality as a quality-of-care problem. The truth is that our social ills kill more babies, while our advanced technology gives us the hope of saving even the tiniest. Babies deemed nonviable in other countries get treatment in the U.S. Also, malpractice litigation affects costs far more than your report suggests. Whether it's cesarean sections, MRIs, or fetal monitors, the threat of litigation drives utilization. One liability insurance company, for example, had 40 times as many claims over failure to do cesareans than claims for doing the procedure. Physicians want meaningful reform, but they fear a "new" plan that merely trades one problem, such as the uninsured, for another, such as strict bureaucratic rationing of health care.

Robert N. Moyers, MD
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The Challenge Ahead

Maria T. Montesano
Assistant Managing Editor

This month the State Society will inaugurate its 143rd president. This article offers an introduction to the physician who will assume that role and overviews his most significant challenge for the year to come.

"Someone in our profession has to work to keep the rest of us free to be able to take care of our patients as best we know how."



Donald G. Ferguson, MD, 143rd president of the Pennsylvania Medical Society

Children are often asked, "What do you want to be when you grow up?," and their answers vary and change as they grow. But that was not the case with Donald G. Ferguson, MD. He says that "from as early as I can remember, I wanted to be a doctor."

On becoming and being a doctor

Dr. Ferguson, a second-generation physician, grew up and was educated in the suburbs of Pittsburgh. He received his bachelor's degree and medical degree from the University of Pittsburgh; and after completing an internship at the South Side Hospital of Pittsburgh, he entered the Army: "At that time, everybody had to spend some time in the military, and I got away not only from Pittsburgh but from the United States for a while."

Upon his return from service, he headed to New York to train at the Memorial Center for Cancer and Allied Diseases, and then to Philadelphia where he joined the faculty of Jefferson Medical College. Eventually he returned to the "new" Pittsburgh, where he has been in private practice as a specialist in diagnostic radiology and nuclear medicine for most of his career.

"I think I continue to enjoy what I'm doing just about every day of my life," he says, "because I know that I'm trying to do something to build; something to help our profession; and something where, at the end of the day, I have a feeling of accomplishment and hopefully have made somebody feel a little better in the process." That sentiment, coupled with a genuine concern for the profession of medicine, has led Dr. Ferguson to his position as president of the Pennsylvania Medical Society.

Concern for the profession

Dr. Ferguson has been a member of organized medicine for a number of years: "I think it's a matter of giving something back to your profession for all that the profession has been to you," he says. He started by serving county and specialty societies, but "over the years that has evolved into becoming more interlocked with the State Society and the American Medical Association."

He joined the State Society in 1954 and has served as chairman of the Council on Governmental Relations; vice chairman of PAMPAC; and a member of the Executive Committee, the Council on Legislation, the Task Force on Medical Liability Reform, and many others. He has also served on the AMA delegation since 1987. For Dr. Ferguson, becoming president "was just a natural progression."

On organized medicine

The basic function of organized medicine, he says, is "to protect the patients that we serve and protect our ability to take care of those patients." Yet he believes outside forces have created added pressure over time, and the constraints physicians must work under have become more difficult each year.

The most significant of such constraints today, according to Dr. Ferguson, "is the increasing regulation and the increasing intrusion of government into physicians' offices—into the lives of not only our profession and our auxiliary professions, but the way in which we are able to treat our patients."

"It has been a gradual process of increasing regulation ever since I was aware there was such a thing as government and that it had any direct influence on the practice of medicine," he says. It certainly is becoming more difficult to face a patient one-on-one and do what you think is proper without having to be concerned about who else is interested in the process and who else will have an influence on the process."

The challenge ahead

Dr. Ferguson believes organized medicine does a great deal to keep the patient-physician relationship alive and protected. Yet, many challenges exist for any incoming

president, and he is also fully aware of that: "Challenges have always been there and they always will be. The nature of any challenge depends on the climate of the day, but the most significant challenge is still what it has always been—to be able to take care of our patients as best we know how with as little interference with good medicine as we can hope to achieve."

He explains: "More and more we're being faced with constraints—monetary constraints, budgetary constraints, regulatory constraints—such as those I was talking about before. The most significant thing [medical] societies are able to do for physicians is to minimize [outside] interference with relationships with their patients."

"Someone in our profession has to work to keep the rest of us free to be able to take care of our patients as best we know how," he continues. "That's what I will try to do, and that's what we have to work to do. That's what medicine is all about—taking care of people."

Message to the membership

Each year the president speaks to the House of Delegates about the year to come. Dr. Ferguson's message this year might very well resemble the following message he offered for the membership as a whole:

The one thing I'd like to tell the members of the Pennsylvania Medical Society is to stay in there. Continue to take care of your patients. We will help you do it, and please help us do it.

The best thing you can do for your patients is to speak up when you know that their welfare is being threatened. Speak up to us—the Pennsylvania Medical Society, the American Medical Association, your county society. Speak up to your legislators. Speak up to AARP. Speak up to anyone who will listen and help when you say, "I need this for the benefit of my patients." Stay involved. Get involved. Keep working to keep your profession free.

Dr. Ferguson resides in Canonsburg with his wife, Anne. He will be sworn in as the State Society's 143rd president on Saturday, October 24, during the Society's annual business meeting.

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Canadian Physicians Debate Reform and Repairs to an Eroding System

David Woods

Health care reform has become a concern of international proportion and remains a top issue of discussion, as seen in this article covering the Canadian Medical Society's annual meeting held in Newfoundland in July.

Canadian physicians must say no to further erosion of that country's health care system; they must help to restructure the system rather than dismantle it; they must educate the public—their patients—about the costs of the health care system and should expect that the public will bear some responsibility for its own health care; and, above all, physicians must continue to be advocates for their patients.

That was the message of incoming Canadian Medical Association (CMA) president, Ronald F. Whelan, MD, in his inaugural speech to some 700 delegates attending the CMA's 125th annual meeting and the first ever to be held in the province of Newfoundland.

Dr. Whelan went on to say that "the velvet glove is not working. Government is not listening. They do not believe that physicians are serious advocates for their patients. What they do believe is that physicians have only their own interests at heart. In becoming creditable advocates of our patients," he added, "we must show fang and claw."

Dr. Whelan, a St. Johns' radiologist and a former chairman of the board of the 46,000-member association, said that he was assuming the presidency at a time when the Canadian medical profession is undergoing a great deal of stress, when physicians see their role as changing. He urged that MDs must be the agents of that change rather than its victims.

In fact, delegates to the association's general council, or "Parliament," voted strongly in favor of a proposal that would allow for the injection of other forms of funding into the now totally government-funded (or monopsonistic, "single payer") universal Medicare system that has been in place in Canada since the early 1970s.

Delegates first of all defeated a Quebec resolution calling for the CMA to disassociate itself from any attempt to enshrine "the present monopolistic medical insurance model in the Canadian Constitution." They later overwhelmingly endorsed a somewhat similar resolution calling for the CMA to provide leadership in urging governments to amend current legislation to permit "the emergence and development of both alternative and complementary private health care insurance and health care arrangements to meet the needs of patients and physicians, particularly in matters of free choice, access, availability, and quality."

Speaking from the floor, Victor Dirnfeld, MD, a Vancouver internist who is vice chairman of the CMA's Council on Health Policy and Economics, said that this resolution was an idea whose time has finally come. He said that provincial governments have a monopolistic position so far as funding is concerned—a position that Dr. Dirnfeld described as uncomfortable, unreasonable, and all-controlling. He was careful to point out that the resolution, far from being an attack on Canada's publicly popular universal Medicare system, was rather an infusion of funds that will reduce fiscal pressures on the system and expand services.

In an interview, Dr. Dirnfeld said that he felt there had been a leftward drift in organized medicine in Canada. Some have despaired that there has been an abandonment of conservative economic philosophy by the mainstream leadership for what have appeared to be pragmatic reasons. The reason for this, he said, is a perceived need to achieve greater cooperation from provincial governments. In essence, organized medicine has tried to buy peace—and that, he added, hasn't worked.

Noting that a generation of Canadian MDs has known no other form of practice than the current universal government-sponsored approach, Dr. Dirnfeld said the

"...the evils of this kind of system have manifested themselves, and frustrated and angered the majority of the profession."

David Woods, a former editor-in-chief of the **Canadian Medical Association Journal**, *is vice president, publications, ECRI, Plymouth Meeting.*

evils of this kind of a system have manifested themselves, and have frustrated and angered the majority of the profession. Americans and their politicians should be very careful before they embark on a Canadian style health care system, he concluded, because such a system results in delays, rationing, and lowered standards.

Augustin Roy, MD, registrar and president of Quebec's College of Physicians and Surgeons, pointed out that Canada does not have the fiscal resources to offer unlimited, free health care. "We are living above our means," he said, and therefore can't enshrine "the present monopolistic medical insurance model" in the Canadian Constitution.

Warming to this theme, Dr. Roy said: "We have spent like crazy sailors for the past 20 years, but we are going to be in economic difficulties for a long, long time...the Canada Health Act has us in a straightjacket. It's too restrictive; it's not a religion, Medicare. It can be changed."

That same Canada Health Act—which precludes any form of patient payment, such as user fees—also removed the right of Canadian physicians to engage in so-called extra billing (i.e., billing above fee schedules negotiated by each province's physicians with their provincial government) because health care in Canada is a matter of provincial jurisdiction.

A further resolution, proposed by the British Columbia delegation, called for changes to the Canada Health Act "to allow creative problem-solving initiatives and to permit the additional funding measures that are necessary for the continued implementation of these principles—the survival of high-quality health care for all Canadians." The principles referred to are the five tenants upon which Canada's Medicare system was founded: that it be universal, comprehensive, portable, accessible, and publicly administered.

General Council approved the resolution. Hedy Fry, MD, a former president of the British Columbia Medical Association, had proposed the resolution and commented that funding cuts are compromising those principles.

Physician remuneration

Concerning physician remuneration, General Council then passed a resolution calling for fair and reasonable remuneration for the full spectrum of professional activities, the liberty to choose among payment modalities, the paying agencies to fulfill the terms of agreements negotiated with legitimate agents of the medical profession, and any failure of negotiations relating to physician compensation to be resolved by a mutually agreed upon and timely dispute-resolution mechanism.

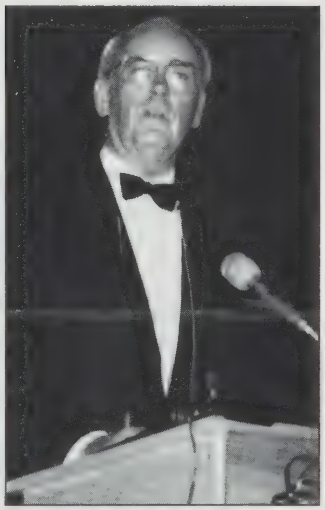
After presenting an addendum to this resolution calling for paying agencies (i.e., government) to be obliged to honor mutually agreed upon negotiated fee schedules, Dr. Fry said the addendum was intended to "stop the totalitarian behavior by governments," a reference to the present situation in British Columbia where that province's socialist New Democratic Party (NDP) government has allegedly reneged on a previously agreed upon fee settlement with the province's 6,000 physicians.

This state of affairs caused a number of British Columbia delegates to the Newfoundland convention to sport black, short-sleeved T-shirts bearing the inscription "I'm a mad Doc." Explaining this phenomenon, one of the T-shirt wearers, Bill Thomas, MD, a Vancouver gynecologist and a former CMA president, said it is a way of expressing outrage at the NDP government's reneging on election promises to treat physicians fairly and reasonably. In fact, said Dr. Thomas, it has done the opposite.

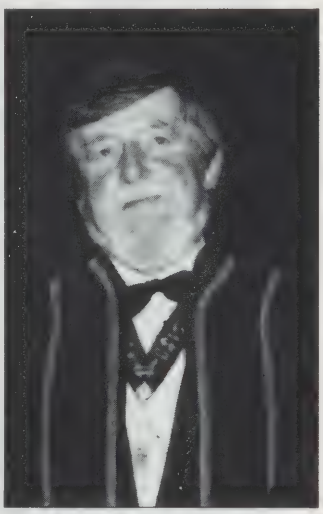
The NDP government has removed the master agreement on negotiated fee schedules between the government and the BCMA. It wiped out the agreement between MDs and the government on such shared responsibilities as accreditation and patterns of practice. Right now, he said, there is no fee schedule agreement, and so there is no basis for negotiation. Furthermore, said Dr. Thomas, the previous government had agreed to put in place a government-funded pension scheme for physicians, but the NDP canceled it.

As well as the "mad Doc" scheme, many British Columbia physicians have taken to placing in their offices photographs of provincial politicians bearing the caption, "This person may be dangerous to your health." Has the campaign worked? Well, the government gave itself the authority to cap the gross income for specialists and family physicians. In addition, there is a global cap on all health care funding.

To underscore this, former CMA president John O'Brien-Bell, MD, said everything physicians earn, they earn by hard work based on modest fee schedules. He pointed out that the ex-president of a British Columbia hospital earns $200,000



AMA President Elect Joseph Painter, MD



Ronald F. Whelan, MD, new Canadian Medical Association President

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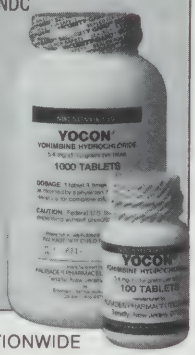
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References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
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and said, "We are being scapegoated for the problems of Medicare. [Physicians require a charter because] our liberties as a profession need to be attended to."

For some years, and at considerable cost, CMA mounted a legal challenge to the Canada Health Act, but withdrew that challenge provided that "the legitimate concerns of the public, the CMA, and its divisions with respect to the implementation of the act are addressed."

As far back as 1986, CMA issued a policy statement on physician remuneration, which read in part that "the Association upholds the rights of physicians to determine the methods of remuneration and to negotiate their fees with their patients. In determining their fees, physicians should be counseled by the fee guide approved by their provincial associations. CMA believes that the most responsible relationship exists when professional and financial agreements are between the physician and the patient, with fee-for-service as the best method of payment for the great majority of, but not all, medical services. CMA supports provincial medical associations in seeking recognition as the sole bargaining agents for physicians. Time protocols should be established in all negotiated agreements."

That much of this appears to have been eroded has angered many Canadian physicians. As retiring CMA president, Carole Guzman, MD, said in her valedictory address: "Canadian MDs are concerned about the apparent conflict between their role as patients' advocates and their responsibilities to the system, as well as the enormous demands being placed upon them in the area of continuing competence at a time of heightened expectations and increased complexity of medical science...I saw a profession that is angry—justifiably so—about unwarranted public criticism, unfair generalizations about appropriateness of medical services, and illogical conclusions that fee-for-service remuneration is the root of all evil."

An invited guest at the meeting was American Medical Association (AMA) President Elect Joseph Painter, MD, of Houston. According to Dr. Painter, it is clear that the costs of medical care are a concern worldwide, and the pressures in Canada are obviously a major concern. He said the proceedings of General Council were courtly and well organized, with the approach to deliberation on all topics clearly mapped out in advance and based upon comprehensive review and resource material. He added that the thrust appeared to be towards building bridges and forming consensus.

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The French National Health Care System—Some Perspectives

Michael S. Marrone, MD
Sandra A. Marrone

When we left for Paris in December 1991, Pennsylvanians had recently elected Senator Harris Wofford largely because he supports national health care. Our country was abuzz with talk about how such a system would work.

Good health care for all citizens is certainly in the national interest, but to work well, a system must be studied and organized carefully. We had heard much about the benefits and the shortcomings of the Canadian and British systems. We thought perhaps France, too, had something to teach the U.S. Therefore, during a visit to Paris last year, we wanted to meet a family physician—a generalist to the French—and learn about that country's program.

Thanks to the efforts of our son's Parisian friends, we met Docteur Gilles Wilmouth at his office in the Montmartre section of Paris on a drizzly Friday afternoon. From him and some research we saw various sides of French national health care that bear careful consideration.



photo by Scott Marrone

Docteur Wilmouth

Dr. Marrone is a family physician practicing in Palmyra and medical director for the Pennsylvania State Police. He is a member of the State Society, past president of the Lebanon County Medical Society, and a diplomat of the American Academy of Family Physicians. Sandra Marrone is the office manager for her husband's practice and a freelance writer.

Learning *about* the French system

When we began to question Dr. Wilmouth, he prefaced his remarks in rough, but understandable English saying, "My own way of work is mine and absolutely mine. So, my answers are mine." He then said he was a "private" physician, one who works *outside* the French health care program.

In the U.S., physicians usually have patients from the public roles—Medicare and Medicaid patients—as well as private-pay patients. But in France one cannot have such a mix because "private is private, and public is public," Dr. Wilmouth explained. *American Medical News* reported in 1989 that 25 to 30 percent of French MDs practice independently from the social insurance system. Like them, Dr. Wilmouth, an osteopathic physician, "won't sign up" and accept the low government fee caps. Instead, he decides his own fees, and patients pay him directly.

Dr. Wilmouth feels strongly that low government fee caps incline participating physicians to do cursory physical examinations, because a physician must see many patients each day to make enough money to pay overhead and to live. The French government now pays 90ff ($18) for an exam. That amount, while low, equals what Pennsylvania pays a family physician for examining a public assistance patient. In France, where a cup of coffee costs the equivalent of $4, $18 for a medical exam seems especially meager.

So, rather than perform a comprehensive physical, the doctor performs a quick one and sends the patient off for a battery of tests and/or x-rays, which the government also pays for, in hopes that a diagnosis turns up in the results.

In Dr. Wilmouth's opinion, the French government wastes money paying for many tests that would be unnecessary *if* the doctor did a more complete patient history and examination, which is simply practicing good medicine. In sum, if public doctors were paid more, they would do a better exam, order fewer tests, waste less public funds, and give better care. As things are, there is no incentive. If a patient consults Dr. Wilmouth in the private sector, he or she pays between 200ff ($40) and 500ff ($100) for the consultation. He said it "takes a long time to examine each patient, and I am quite good. So, I think that good must be paid."

"You have to listen to the history, you have to think, and you have to be paid, be-

cause the work is to think." He added that only then, if you must, do you order x-rays or tests. "One test, not 20," he said, and only after you know what you are looking for, not as a shot in the dark.

Dr. Wilmouth said he sees many patients who are frustrated with the public system. They come to him after seeing public physicians "who did not find anything. The first one cuts like this. The second one cuts like that," he said as his hand sliced an X through the air. "And no one finds anything." Speaking of a particular patient, he said, "It was easy for me [to make a diagnosis], but no one [before] took the time [to do a good history and physical examination]." Dr. Wilmouth also said practicing medicine within the public system "is replete with filling out papers" and that the government can be slow to pay: "In a few days, in a few weeks, in a few months...."

In addition, public hospitals are problematic because patients must wait as long as three months for admission. The maximum wait to enter a private hospital is three days, and the length of stay is shorter than public hospitals. A private hospital staff does a complete exam and works hard to perform necessary tests as quickly as possible. They know the patient is paying, and the cost must be affordable.

Learning *from* the French system

On the other hand, public hospitals, said Dr. Wilmouth, stretch out the hospitalization to make more money. They do several tests over a longer time period. They do x-rays one day, blood tests the next, EKGs the next, and so on, so they can bill the government for each test and each overnight stay. According to *American Medical News*, "hospital stays account for 50 percent of total health care costs" in France partly because "lengths of stay are long." Meanwhile the line of patients waiting to get in grows longer.

On the brighter side, former Surgeon General C. Everett Koop, MD, reported on PBS last fall that French babies are among the healthiest in the world because of the French health care system. France has the ninth lowest infant mortality rate in the world, and the U.S. ranks twenty-second, according to the National Center for Health Statistics.

When a pregnancy is confirmed in France, the government sends the woman a manual about prenatal care and instructions to go for seven free examinations during pregnancy. If she keeps the appointments, she gets an outright gift of 5000ff ($1000) when the baby is born, said Dr. Koop. And the money is available to all French women, not just the poor. The philosophy is, "why stigmatize the poor by singling them out. Give the money to all. In the long run it is cost effective to have healthy babies."

As a result of this program, 95 percent of French women have received prenatal care for the last 30 years. In the U.S. in 1990, a half million women had no access to prenatal care.

The other cost-effective factor is that *sages-femmes* (midwives), not doctors, do most prenatal care and half of all deliveries.

Thinking about ways physicians might cut costs, we asked Dr. Wilmouth about malpractice costs in his country. His answer revealed much about French—and in contrast, American—attitudes toward physicians. He said malpractice lawsuits are rare in France. In fact, he doesn't "have to pay a special insurance for this problem...I can tell you that the total of my liability insurance for walls [office property] and my specialty is for one year 3500ff ($700)." That's cost effective.

It is easy to agree that America's health care system must be changed. But the revamping requires much thought, not to mention cooperation, among patients (the consumers), the government, physicians, hospital administrators, and insurance carriers.

With responsible input from *all* these sectors and careful study of other health care systems, including France's, our expensive and often unfair system may be revised to offer good care to all at reasonable cost.



photo by Scott Marrone

Dr. Wilmouth's office is on the rue Caulaincourt in the Monmartre section of Paris.

Discussing the Issues with the Senatorial Candidates

Department of Governmental Relations and Maria T. Montesano, Assistant Managing Editor

Both of Pennsylvania's senatorial candidates were offered the opportunity to participate in a PENNSYLVANIA MEDICINE interview. The following interview with incumbent Senator Arlen Specter took place in his Philadelphia office in early September. Questions were posed by: Robert N. Moyers, MD, Society president; Howard A. Richter, MD, vice speaker of the House of Delegates; and Roger F. Mecum, executive vice president. Although Lynn Yeakel could not schedule an interview in time for publication, she did respond to several statements pertaining to positions held by the State Society and AMA, and provided her position on other health care issues.

"We have the greatest health care system in the world. I'm not prepared to scrap it, as some are, on titles which boil down to socialized medicine."

—Senator Arlen Specter

Interview with Senator Specter

Dr. Moyers: There is a great concern among the medical profession about where we're headed: the heavy increasing administrative burden takes us away from patient care; and at the same time everyone is concerned about the increasing cost of care. Also, we are concerned about some of the health care proposals that are out there...The system continues to encourage the high price of specialists—not that we don't need them, we do, but we have gotten out of balance...The end result, unless we change it, is that medical care will be delivered fragmented, system by system, by subspecialists, and that's very expensive.

Senator Specter: That's one of the reasons that I think we need to take a look at managed health care. I'm not an expert at it, but I have looked at it and I think it has possibilities.

Dr. Moyers: We also favor managed care, but one of the problems we see is that sometimes, if the wrong kind of incentives are built into the managed care system, they reduce care that may be appropriate.

Senator Specter: Well, it's a question of how you manage it and a matter of some experimentation. We know that the current system is in urgent need of improvement...I'm against rationing of care—I do not like the Canadian system. I don't want it for myself, my family, or America. The question of how you pay for care is something which the system has to work out, but the real question is whether you have the resources to do the job, and I think we do...We have the greatest health care delivery system in the world. Now, we have to build on it. I'm not prepared to scrap it, as some are, on titles which boil down to socialized medicine. We need preventative care, and we need to take a close look at cost containment and other issues and work on them from that point of view.

Dr. Richter: Senator, I look at this problem a little bit differently. The biggest problem that my colleagues who send me patients have is the "hassle factor"—dealing with the rules and regulations—and it is particularly bad in two areas—Medicare and Medicaid. The third-party payer's are intrusive, but the worst intrusiveness is from the government...The more that we can get rid of the "hassle factor," the better off we will be.

Mecum: Senator, we would appreciate hearing your thoughts on the whole area of Medicare. We have been trying to work with and struggle through the transition into the resource based relative value scale (RBRVS) payment system which began this past January, [and] we know there is, at least in Washington and other parts of the country, an attempt to try to mandate that the Medicare payment system be applied to private insurance.

Senator Specter: I have not been pleased with this outcome. Back in June of last year, approximately 1,000 Pennsylvania physicians contacted my office expressing their concerns with HCFA's (the Health Care Financing Administration's) proposed regulations for RBRVS. In response, I contacted [former HCFA administrator] Dr. Gail Wilensky to express these concerns, particularly the behavioral offset component which was modified in the final regulations.

Another issue brought to my attention which I'm trying to correct is the failure to

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OCTOBER 1992

October 14, 1992
MECHANISMS OF GUT PEPTIDES IN NEUROENDOCRINE DISORDERS
Thomas O'Dorislo, M.D.
Professor of Medicine and Physiology
Director, Division of Endocrinology
Ohio State University, Columbus, Ohio

October 21, 1992
PULMONARY DISEASE
Jay N. Nadel, M.D.
Professor of Medicine and Physiology
Chief, Section of Pulmonary Diseases
Director, Multidisciplinary Training Program in Lung Diseases, C.V.R.I.
University of California/San Francisco
San Francisco, CA

October 28, 1992
NEW APPROACHES TO IDENTIFICATION OF MYOCARDIAL ISCHEMIA
Leonard S. Dreifus, M.D.
Professor of Medicine
DIrector, Division of Cardiology
Hahnemann University
J. Yasha Kresh, Ph.D.
Professor of Medicine
Director of Cardiothoracic Surgical Research and Director of Cardiovascular Biophysics and Computing
Division of Cardiovascular Diseases
Hahnemann University
Amir Pelleg, Ph.D.
Professor of Medicine
Division of Cardiovascular Diseases
Hahnemann University

NOVEMBER 1992

November 4, 1992
HYPOTHYROIDISM: PATHOGENESIS AND IMMUNE MECHANISMS
E. Chester Ridgway, III, M.D.
Professor of Medicine
Head, Division of Endocrinology
University of Colorado Health Science Center
Denver, CO

November 11, 1992
LV REMODELING: CELLULAR AND THERAPEUTIC CONSIDERATIONS
Gary S. Francis, M.D.
Professor of Medicine
Cardiovascular Division
University of Minnesota School of Medicine
Minneapolis, MN

November 18, 1992
MECHANISMS AND NEW STRATEGIES FOR TREATING AUTOIMMUNE DISEASES
David Wotsy, M.D.
Associate Professor of Medicine
Chief, Rheumatology Division
San Francisco VA Medical Center
San Francisco, CA

November 25, 1992
Thanksgiving Holidays – No Grand Rounds

DECEMBER 1992

December 2, 1992
ASTHMA BY INGESTION: ASPIRIN, SULFITE, M.S.G., & TARTRAZINE SENSITIVITY
Ronald Simon, M.D.
Associate Clinical Professor of Medicine & Pediatrics
University of California/San Diego School of Medicine
Head, Division of Allergy & Clinical Immunology
Scripps Clinic and Research Foundation
La Jolla, CA

December 9, 1992
CHOLESTEROL REDUCTION IN PRIMARY PREVENTION: UNANSWERED QUESTIONS AND UNQUESTIONED ANSWERS
Jeremy Swan, M.D., Ph.D.
Professor of Medicine
UCLA School of Medicine
Los Angeles, CA

December 16, 1992
BREAST CANCER: DIAGNOSIS AND TREATMENT
Michael P. Moore, M.D., Ph.D.
Assistant Professor of Surgery
Cornell University School of Medicine
Sloan-Kattering Cancer Center
New York, NY

December 23, 1992
Christmas Holidays -- No Grand Rounds

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October 21, 1992
PULMONARY MEDICINE
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Guest Faculty: Jay A. Nadal, M.D.

November 18, 1992
MECHANISMS AND STRATEGIES FOR TREATING AUTOIMMUNE DISEASES
Course Director: Richard L. Spielvogel, M.D.
Guest Faculty: Alice Gottlieb, MD
Richard P. MacDermott, M.D.
David Wotsy, M.D.

December 2, 1992
ASTHMA
Course Director: David M. Lang, M.D.
Guest Faculty: Ronald Simon, M.D.

December 16, 1992
BREAST CANCER: DIAGNOSIS AND TREATMENT
Course Codirectors: Jeffrey Brodsky, M.D.
Pamela Crilley, D.O.
Guest Faculty: Michael P. Moore, M.D., Ph.D.

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Senator Arlen Specter

pay some specialities for electrocardiograms (EKGs), which are a very basic research tool and very unfairly bundled into other payments. I am a co-sponsor of legislation introduced in the Senate which would provide for corrections with respect to separate EKG reimbursement, as well as equitable payments to new physicians and other issues related to the implementation of RBRVS and physician payment reform.

These issues are illustrative of the problems faced in the medical field...The whole regulatory system is out of touch. HCFA is an agency which is extremely difficult to deal with, but Dr. Wilensky comes before our appropriation subcommittee to justify the agency's budget request, and I am able to be helpful to Pennsylvania interests there...People don't understand how important experience is in fighting the bureaucracy. If I'm not in the Senate next year, Pennsylvania will rank 50 among the 50 states in seniority.

Mecum: What about tying the Medicare system to other issues? In Pennsylvania, auto insurance has been tied to Medicare, and along with that goes the Medicare "hassle factor," which Dr. Richter mentioned, and all the Medicare policies that come with it. Now the governor is trying to do the same thing with workers' compensation, and as mentioned earlier, at the national level there are proposals to mandate the Medicare system to the private health care insurance industry.

Senator Specter: There are too many problems in Medicare to use it as a role model, with all due respect...As for the "hassle factor," the only way I've seen to deal with that is on the specifics.

Dr. Richter: One other issue at the federal level we've got to at least mention is the Medicaid program in terms of letting the states have too much leeway...We need to set up a priority system in Medicaid, and I'm afraid that no state is going to do that without the federal government telling them.

Senator Specter: We are taking a stand on state practices in a number of ways. For example, one of the aspects of Senate Bill 1936, which I am co-sponsoring, supercedes state practices where you have health coverage. We want to see people able to buy specifically what they want without having a regulatory process in the states putting health care in a straightjacket.

Dr. Moyers: Senator, what future prospects do you see for significant tort reform?

Senator Specter: I see the possibility of some changes in the tort system arising from the legislation which we will take up the day we go back to the Senate. There are some provisions to expedite medical malpractice settlements, which I think can be done, and there is a requirement for states to develop voluntary alternative dispute resolution procedures. This is the first time in my 12 years in the Senate that we have approached tort reform quite like this, [and] I think it's going to be a very worthwhile experience....

Another medical issue I want to mention that is of great concern to me is that of infant mortality. I was appalled by [the



State Society President Robert N. Moyers, MD, and Vice Speaker of the House of Delegates Howard A. Richter, MD, questioned Senator Arlen Specter in his Philadelphia office.

fact that] in 1984 Pittsburgh had the highest infant mortality rate of any city in the country of African-American babies. Dr. C. Everett Koop made a suggestion, which I put in a bill, to pay teenage pregnant women $500 if they will get four prenatal care and one postnatal care check-ups, and undergo schooling on prenatal care and parenting. I know it's going to be controversial, but I've seen the figures and this would be a multi-billion dollar savings.

Dr. Moyers: To provide an incentive for them to *go* and get that prenatal care is important. In most cities, the clinics are there and available to be used, if you can get the people in to use them. It's not that there's not an availability.

Senator Specter: That's my point, doctor. You've got the greatest medical system in the world, and it's a question of how you use it.

Dr. Richter: I think solving the access problem is more than a medical problem, it is a social problem.

Senator Specter: And that's where the government can help, with things like the incentives.

Dr. Moyers: Senator, let me give you an example I think is meaningful in this conversation. When we talk about the underlying stimulus for all this heath reform, it's the cost...The new OSHA requirements apply equally to my little office as they do to a blood bank lab that may draw blood from hundreds of people a day. The cost to implement those regulations in my office is going to be maybe $3,000 or so. That is just one example of how the government's regulations and requirements keep adding to the cost of delivering medical care. And unfortunately, Medicare, Medicaid, and many of the third-party payers are not increasing their payments to reflect increased overhead. When we talk about cost, so much of it comes from requirements from outside forces.

Senator Specter: If you would give me a one-page memo on that, I will take it up with OSHA. Frequently the rule has some other purpose and stretches the regulation too far. It is possible to slice the apple in a way which will accomplish whatever it is they want and leave you out.

Responses from Lynn Yeakel

Following are responses from candidate Yeakel to questions posed by the Pennsylvania Medical Political Action Committee (PAMPAC) in a survey mailed to her office in June.

Society Position: Pennsylvania physicians should be granted an exemption from the federal Clinical Laboratory Improvement Act of 1988 because Pennsylvania regulations are as stringent as federal regulations.

Candidate Yeakel: Agree.

Society Position: The new resource based relative value scale (RBRVS) Medicare physician payment system should be fully implemented without further Medicare payment restrictions.

Candidate Yeakel: The five-year phase-in period for the Part B RBRVS Medicare physician payment system only began this year. While it may be premature to talk about actual changes in the fee schedule, I am aware that general and informal discussions to modify the payment scheme for surgical and non-surgical volume performance standards have arisen. Last month, Health and Human Services Secretary Louis Sullivan, MD, recommended changes in the transition fee. I have not had the opportunity to review the specifics of the proposal and consequently have no opinion on its merit.

Society Position: Medicare reimbursement mechanisms should not be expanded into the private sector.

Candidate Yeakel: I would have to study further the implications of expanding Medicare reimbursement mechanisms into the private sector and would want to know the extent to which such mechanisms are already being used as informal benchmarks by private insurers and what consequences follow from such use.

Society Position: The Medicare Physician Regulatory Relief Amendments of 1991 (H.R. 2695, S. 1332) should be adopted as they would greatly reduce the administrative burden of the practice of medicine.

Candidate Yeakel: I very much favor proposals aimed at reducing the administrative and bureaucratic burdens of our present system, as they contribute to the system's cost and inefficiency. According to a recent GAO study, however, fraudulent health care billing practices contribute as much as $70 billion to the cost of the system. It seems clear that the current level of burdensome paperwork does not serve as an adequate check on abuse. More paperwork is most certainly not the answer. These two issues should be treated as separate sides of the same coin, and I would want to satisfy myself that the Medicare Physician Regulatory Relief Amendments adequately promote reductions in both administrative overhead and fraud.

Society Position: As the state's Medicare Carrier, Pennsylvania Blue Shield should be required to re-evaluate in-state locality designations as part of Medicare payment reform.

Candidate Yeakel: I am unclear as to the actual need to mandate re-evaluations of in-state locality designations. Re-evaluation has arisen in the context of Lancaster County's bid for a locality fee change and also in reference to several hospitals. Whether these cases indicate the need for a federally legislated directive governing rural-urban fee differentials, or perhaps the creation of a statewide locality, is something I would need to consider in greater detail.

Society Position: Separate physician reimbursement for the professional component of EKG analysis should be restored.

Candidate Yeakel: Agree

Society Position: Medical liability reform could be a prominent factor in containing health care costs.

Candidate Yeakel: Agree

Society Position: Physicians should be allowed to test patients for HIV, maintaining the patients' privacy but without explicit consent, when a health care worker has been placed at risk by exposure to body fluids.

Candidate Yeakel: I disagree with the question because it represents a vague and incomplete statement of the issue, not because I dismiss the safety concerns of health care workers. We need to further investigate the issues of what constitutes a reasonable risk of exposure, when does the risk arise, and what reciprocal obligations are owed health care providers and patients. I am reviewing the recommendations developed by the Centers for Disease Control (CDC) for preventing transmission of HIV and hepatitis B virus (HBV). I note with interest CDC's recommendations that: 1) health care workers who perform "exposure-prone procedures" should know their HIV and HBV status; 2) health care workers who are infected with HIV or HBV should not perform exposure-prone procedures absent counsel and review from an expert panel; and 3) mandatory testing of health care workers for HIV is not recommended. I support CDC's conclusion that clearer definitions are needed of the nature, frequency, and circumstances of blood contact between patients and health care workers during invasive procedures, and that new "devices, protective barriers, and techniques" to prevent blood contact should be developed and evaluated.

"Whether the ultimate funding mechanism is the single-payer model, the employer-based method, or a hybrid of the two, we must get health care costs under control and get American health care providers on a budget."

—Lynn Yeakel

"MAKING AMERICA HEALTHY": Lynn Yeakel's Plan for National Health Insurance

The national debate about health care rages, especially with the upcoming election. Every candidate, from the president to the Senate, is being asked to present his or her viewpoint.

According to senatorial candidate Lynn Yeakel's position paper, "Making America Healthy: A Plan for National Health Insurance," "comprehensive health care can no longer be a privilege available only for the few who have the means to pay for it. Affordable health care is a right and must be accessible to every American, [and] reform of our health care system is an essential element of [my] economic recovery plan." Yeakel supports "universal health care coverage proposals which most effectively control escalating costs, emphasize preventive care, and preserve full customer choice of physicians and other care providers."

Yeakel also believes "on-balance, single-payer health care reform proposals in which *government serves as the insurer, though not the provider of services,* have the greatest potential for meeting [my] long-term goals," which include:

- Provide comprehensive and affordable health insurance for all Americans—emphasizing preventive care for the very young, cancer screening programs for adults, and nursing home care for the aged.
- Control spiraling costs by reducing wasteful administrative and billing overhead, and by establishing a national health care budget to guide in containing overall expenditures.
- Create *real* relief for the middle class, with a target of $1,000 to $1,500 in savings on out-of-pocket costs for the average family.
- Help American business be more competitive globally by reducing average payroll costs for health insurance from 13 percent (the average for 1991) to a target range of 7-9 percent.
- Reflect the special needs and problems of small business.
- Establish an adequate level of benefits and eliminate limitations on coverage for pre-existing medical conditions.

Realizing cost is one of the biggest concerns of any health care reform, Yeakel concludes, "We need to consolidate under one umbrella the various sources of revenue...and share those costs in an equitable manner. Whether the ultimate funding mechanism is the single-payer model, the employer-based method, or a hybrid of the two, we must get health care costs under control and get American health care providers on a budget. With comprehensive, affordable health care for all Americans, we can make our nation healthy again."

First Public Release of Physician-Specific Data by Council Is Imminent

John A. Malcolm Jr., MD

Only a scant two or three weeks remain until the expected public release of the first consumer report of physician-specific data from the Pennsylvania Health Care Cost Containment Council (PHC4).

Coronary Artery Bypass Graft (CABG) surgery is still the topic, and the Society's Task Force on Health Care Cost Containment and the Joint Committee on Health Care Data have worked long and hard to successfully convince PHC4 to take out the most onerous and statistically unsupportable sections, such as morbidity, from the originally proposed report.

The task force and committee have been very successful, and what remains in the report has been independently validated. All of Pennsylvania's approximately 200 operating surgeons who did CABG surgery during 1990 will see their names in print in the 50-page report.

The report is likely to be the prototype for future physician-specific reports, so it behooves all physicians to be aware of the types of data that will be included in the report. They should also be aware of projections for future types of data to be included in both the PHC4 report and in proposed proprietary published data soon to enter the scene in Pennsylvania.

The following data is expected to be included in the "consumer" edition of PHC4's physician specific report on CABG surgery due early next month:

- An alphabetical listing of Pennsylvania physicians performing CABG surgery, including: 1) hospitals where they performed CABG surgery; and 2) whether they are solo practitioners or in a surgical practice group.
- An alphabetical listing of Pennsylvania hospitals in which CABG surgery and other open heart surgical procedures are performed, including: 1) the total number of CABG surgery procedures performed; and 2) the total number of all open heart surgical procedures.
- An alphabetical listing of Pennsylvania hospitals in which CABG surgery was performed in 1990, including: 1) the total number of CABG surgery patients; 2) the actual mortality of CABG surgery patients; 3) the expected range of mortality for CABG surgery patients; 4) a statistical rating, indicating whether the actual mortality is above, within, or below the expected range; and 5) the average charge by the hospital, exclusive of physician charges.

"The report is likely to be the prototype for future physician-specific reports, so it behooves all physicians to be aware of the types of data that will be included."

- A bar graph of hospital average charges arranged from the lowest to the highest.
- Alphabetical listings of hospitals with their cardiac surgeons by geographic region (western, central/northeast, or southeast Pennsylvania), including: 1) the total number of CABG surgery patients for each operating surgeon and surgical practice group in each hospital; 2) the actual mortality of CABG surgery patients for each operating surgeon and surgical practice group that did 30 or more CABG surgery procedures at the hospital; 3) the expected range of mortality for CABG surgery for each operating surgeon and surgical practice group that did 30 or more CABG surgery procedures at the hospital; and 4) a statistical rating, indicating whether the actual mortality is above, within, or below the expected range.

Physicians are strongly urged to request the Technical Report as well as the Consumer Report, because substantial additions necessary for physicians and hospitals to understand the methodology behind the consumer edition are included in the technical edition. Physician and hospital comments to be included in the consumer edition should be prepared with the knowledge and understanding of the content of the Technical Report. Such information is important in order to answer questions from patients concerning the report and its contents. The communications media will also have the Technical Report and may be expected to use it in their coverage.

This report does not contain individual physician charges, physician training/certification data, or "morbidity" data. However, such information is likely to be included in future PHC4 reports since physician charge profiles already exist, physician training/ certification and specialty information is maintained and published regularly by the American Medical Association and American Osteopathic Association, and more accurate projections of "morbidity" are under development. Currently, a magazine publisher in New York is planning to publish such data—exclusive of morbidity—semiannually on a regional basis in Pennsylvania.

While still far from perfect, the report has been enhanced greatly due to the recommendations of the Society's task force and joint commission. They will continue to work to provide meaningful input in future reports.

Dr. Malcolm is chairman of the Society's Task Force on Health Care Cost Containment and physician representative on the Pennsylvania Health Care Cost Containment Council.

HCFA MONITORING E/M CODE USAGE

More than seven out of ten claims reviewed under the new Medicare payment system for Pennsylvania were coded at the correct evaluation and management (E/M) level, according to final results of an educational process implemented by the Health Care Financing Administration (HCFA) and its Medicare carrier, Pennsylvania Blue Shield.

Results of Medicare's Early Claims Review (ECR) process indicate that 77 percent of claims were coded correctly, and the remaining 23 percent should have been coded at a lower level of care. The process was designed to provide feedback to the physician community regarding the appropriate use of the new E/M codes. Blue Shield analyzed a random sample of 450 claims requested from physicians in Pennsylvania from February 10 through June 30, 1992.

State Society representatives met this summer with Medicare to review preliminary findings. The primary problem areas identified initially from preliminary results were codes 99214 and 99215 for outpatient visits, and codes 99223 and 99232 for inpatient visits. Reductions were made mainly because medical records did not substantiate the medical decision-making level of complexity and/or history.

Information is not yet available as to whether these are the only codes identified as problem areas from the final results. At the request of the Society, Blue Shield agreed to identify cases of undercoding by physicians. The preliminary results did not identify any cases where undercoding occurred.

The final Medicare analysis is specialty specific and shows regional and national comparisons. Though Pennsylvania results seem to coincide with national findings, according to Medicare, the state's physicians appear to have an overall higher rate of correct coding than regionally or nationally.

Medicare has asked for the Society's assistance in formulating an action plan to re-educate physicians as needed based on the final statistics. The Society's plan, which was approved by the Council on Medical Economics in early August, includes continuing communications with Medicare; determining where problems exist; working with specialty societies to address the greatest problems, including special training; and sponsoring reimbursement seminars later this year targeting problem areas.

Comparative Performance Reports

A second carrier activity of importance to physicians involves Comparative Performance Reports, which carriers first sent to approximately 3,500 physicians nationally in 1990.

The reports contained information about individual physicians' Medicare practice patterns—as compared to those of their specialty and locality peers—when their utilization was significantly higher than the norm. The 1990 information covered a broad range of services, including procedures as well as E/M services.

In August, 4,700 physicians who billed in the top five percent for specific E/M codes received Comparative Performance Reports with information solely about visits and consultations. The reports—much more specific than those mailed in 1990—contained information about the number of Medicare beneficiaries that the physician treated during the period analyzed, the number of E/M services billed per beneficiary who received an E/M service, and the average number of E/M services provided for all beneficiaries that the physician treated. Also provided was similar information for the physician's peer group.

The Visit Code Comparative Performance Report program is entirely educational, according to HCFA. Pennsylvania physicians are encouraged to contact Blue Shield to discuss reports. However, they are not obligated to do so, since the intent of the program is to provide physicians with information to help them evaluate their own practice patterns. Also, although these initial reports are informational, repeatedly identified physicians who have not provided an explanation of their utilization patterns could be subject to an audit at some time in the future.

SOCIETY PROTESTS BLUE SHIELD REQUEST

The State Society recently protested a Pennsylvania Blue Shield request for documentation when using monitored anesthesia care (MAC) modifiers.

MAC involves the intra-operative monitoring of a patient's vital physiological signs, in anticipation of the need for administration of general anesthesia or of the development of adverse physiological patient reaction to the surgical procedure. It also includes the performance of a pre-anesthetic examination and evaluation, prescription of the anesthesia care required, administration of any necessary oral or parental medications, and provision of indicated postoperative anesthesia care.

The Medicare program pays for medically reasonable and necessary MAC services furnished by a physician. When reporting MAC services, the "QS" modifier is added to the procedure code.

In mid-June, Medicare began requesting medical record documentation for claims where the "QS" modifier was used. The requirement was imposed on providers by Pennsylvania Blue Shield, the state's Medicare carrier, since MAC is not automatically covered but must be reasonable and medically necessary. To determine this requirement, Blue Shield began requesting documentation on every claim where a "QS" modifier was used.

The State Society protested the action to HCFA, and HCFA agreed that Blue Shield was overzealous in its attempt to determine reasonable and medically necessary by requesting medical records in every case. HCFA, therefore, mandated that Blue Shield refrain from this practice, which it did effective August 4. Blue Shield will automatically handle all claims inappropriately denied, and providers are not responsible to conduct reviews or make any resubmissions.

MEDICAID OMBUDSMAN PROGRAM EXPANDING

The Medicaid Ombudsman Program—an ongoing cooperative effort of the Department of Public Welfare (DPW), the State Society, and county medical societies—continues to expand throughout Pennsylvania.

The program was designed to help physicians and their office staffs address billing, policy, and

enrollment questions about the Medical Assistance (MA) program. Due to budgetary limitations and staff reductions at DPW, access to such information has been a problem.

DPW hopes to reduce program hassles by: 1) training county medical society executives and providers' offices staffs to handle program-associated questions; and 2) offering a hotline for questions which executives and staffs cannot answer.

A training session was held on June 12 for county medical society executives from Berks, Blair, Lycoming, Montgomery, Northumberland, Philadelphia, Schuylkill, and Union counties. DPW is now planning office training sessions for these counties.

The Society has sent letters to presidents of non-participating county medical societies encouraging their involvement in the program.

Note: even if a county does not employ an executive, options exist for participation.

For additional information about the program, call the State Society's Department of Medical Economics at 1-800-228-7823.

Dennis L. Olmstead, the State Society's director of medical economics, contributed to this page.

Pennsylvania Medical Society

Auxiliary

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The object of the Pennsylvania Medical Society Auxiliary is exclusively educational and charitable and to assist in programs of the Pennsylvania Medical Society that improve the health and quality of life for all people. Each community has different needs, and educational materials are provided for volunteers committed to health education and health care legislation. Programs and project ideas are available through the Project Bank catalog.

Physicians' spouses are encouraged to become members of the Medical Auxiliary in these changing times in health care and become knowledgeable so they can communicate with and help educate the community and patients when approached on health-related issues as well as legislation changing the way physicians practice medicine.

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Mrs. Jean Greco,
President, PMSA President

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Hahnemann's "Point of Light"

Maria T. Montesano
Assistant Managing Editor

The Homeless Clinics Project at Hahnemann University, once considered a "band-aid" program, expanded its scope of practice this year. In return, it received national media recognition, as well as designation as a "Point of Light" by the President of the United States. That, however, is not the point.

CNN noticed. *USA Today* noticed. And *American Medical News* noticed. More importantly, a growing number of homeless Philadelphians are noticing...that medical care is becoming available to them through the Homeless Clinics Project at Hahnemann University.

The project—now in its third full year of operation—couples eager-to-learn, first- and second-year medical school students with homeless shelter residents in need of medical attention. The result: hands-on experience for the students and the establishment of continuity of care for the patients.

"We are able to do something that is obviously needed," says Ed Kantor, second-year student and project director. "The homeless population has increased and continues to grow, and the program offers the students clinical exposure within their first two years at Hahnemann."

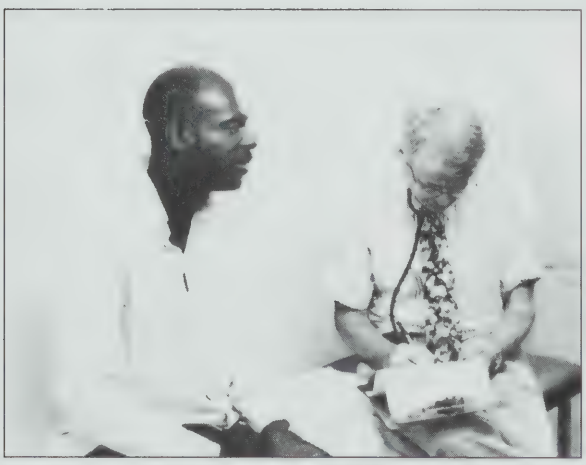


photo by David R. Boyer, Lebanon

Michael Johnson (left), Project Home resident, receives medical care from Wilbur Oaks, MD, professor of medicine at Hahnemann.

As project director, Kantor is responsible for overall administrative duties at the clinics, as well as publicity, fundraising, and motivation. Under him are a series of clinic directors responsible for signing up patients, overseeing the flow of the clinics, making patient referrals, and scheduling clinic volunteers, including students and physicians.

Committees of volunteers and medical students address the use of immunization projects and the computerized tracking of clinical data; the remainder of the volunteers work as student interviewers. All in all, according to Kantor, approximately 200 students volunteer to work in the clinics throughout the course of a year.

Hahnemann students manage the clinics at three city shelters. The original, St. John's Hospice, houses a young to middle-aged homeless population whose medical care needs widely vary. The two new clinics opened earlier this year offer more specialized experiences for physicians and students: the clinic at Project Home's Winter Emergency Shelter tends to men only, many in need of psychiatric care; and the medical care at Trevor's Place, a shelter for women and children, focuses on routine tests and gynecological exams, as well as health education and counseling.

The new clinics also offer an opportunity for increased student involvement: "The main complaint we got from students last year was that they didn't get to volunteer enough," says Ashley Greenspun, director of referrals. "Now, with the three clinics, we're hoping that people get the chance to work more than once or twice a semester."

Visiting Project Home

PENNSYLVANIA MEDICINE's visit to Project Home occurred one hot and humid night in late July. A year ago the house was a Philadelphia crack house, but on this particular night, a number of men are occupying their time with house chores and free-time activities. Because the shelter is mainly a winter emergency shelter, its summer population is light, and the focus changes to one of sobriety.

Tonight's clinic staff consists of seven Hahnemann workers: Kantor; Greenspun; Ted Uroskie Jr., director of physician scheduling for the clinic; Timothy Reiter and John Williams, student interviewers; Mike Freedman, past project director; and Wilbur Oaks, MD, professor of medicine.

The procedure is well defined. Amy

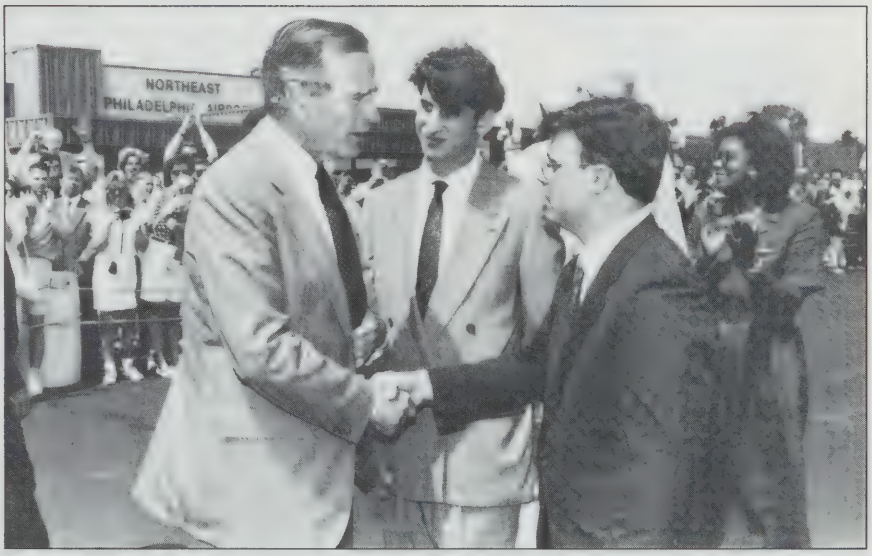
Kaltenmark, director of Project Home, prepares a clinic sign-up sheet for shelter residents. When the physician and students are set up, Kaltenmark presents the patients one-by-one. Student interviewers talk with the patients to gather background information and medical histories, and to find out why they are seeking medical care. Patients then receive medical attention from the physician, referrals are made and medications prescribed as needed, and follow-up is completed by student interviewers.

Tonight, three residents are seeking treatment for skin problems, one possibly as the result of his HIV infection, and one patient referral is made to a surgical clinic. According to Uroskie, although the patient turnout is light due to the season—in winter, between five and 15 patients are treated in a night—this is a typical summer night. He explains that more people seek shelter at Project Home in winter, and the living conditions are "closer," causing colds and tuberculosis to spread quickly. In summer, however, there are a lot more rashes and skin problems.

While the actual patient portion of the night takes less than an hour, much is revealed during the discussion on the ride back to the university. Reiter, who worked a number of times last year as a first-year student, says he gained new insight from his conversation with his patient tonight: "My patient has been homeless for 11 years, is quite intelligent and a reader. He has some interesting views on being homeless...and I was amazed to learn that he has a group of homeless friends. I always think of the homeless as loners."

Kantor talks of both good and bad experiences he has had working in the clinics during the past year. One patient became violent and threatening, particularly toward a female medical student. Of that night, Kantor says, "It brought some reality to the situation—that people are not getting the care and medication they need, including those people who need help with mental problems."

Just as vividly, he remembers his best experience, which took place at Trevor's Place last winter: "A couple of weeks after we started the clinic there, the kids began to hang around us during the clinic visits. They wanted to wear our coats, play with the medical instruments, and learn all about what we were doing."



Ed Kantor (right), clinic project director, and Mike Freedman (center), past project director, greeted President George Bush when he arrived in Philadelphia on a recent visit.

"The children were reaching out for human contacts, and the students were all taken back by that," he says. "Aside from their medical duties, the students are providing positive role models for the kids. That's continuing, and it's good for both the students and the kids."

Receiving national recognition

The kids at Trevor's Place aren't the only ones who have noticed what Hahnemann's medical students have been up to. The students' work was recognized by President George Bush on June 22 as the 809th Daily Point of Light for the Nation. According to a While House release, "Daily Points of Light are those who successfully address our most pressing social problems through direct and consequential acts of community service."

In recognition, the students received a letter of recognition from the President saluting them for exemplifying his belief that, "From now on in America, any definition of a successful life must include serving others." In addition, Kantor and Freedman met up with the President during a summer stop in Philadelphia. Of that experience, Kantor says, "It was interesting. President Bush spent a couple minutes talking with me and Mike [Freedman] about the program. It was neat to meet and be recognized by the President...we hope the recognition will bring

the health care needs of the homeless to the public's attention."

Looking to the future

"We try to expand or add something to the program each year," according to Greenspun. For the coming year, she hopes a proposed outreach program will place clinics on the street for homeless people who don't live in shelters.

"The basic idea is that we would set up a table beside the meal van," says Kantor. "Preliminary contacts have been made for the new program, but there are still a lot of logistics to work out." Other initiatives include expanding educational programs, setting up an immunization program for children at Trevor's Place, and integrating volunteers from Hahnemann's physician assistant program into the overall project.

Kantor's efforts also extend to fundraising. The Homeless Clinics, sponsored by Hahnemann's Department of Medicine, have received grants this year from several sources, including Quaker Chemical, the Esther Gowen Hood Trust, and Sister Mary Scullion. Hahnemann continues to submit applications for other grants, and Kantor is working with Hahnemann's Development Office to expand its alumni support as well.

Benefiting all involved

Of Hahnemann's Homeless Clinics, Rick Anderson, MD, one of the project's founders, once said, "Right now, our program is just a band-aid." Asked to comment on that statement, Kantor jokingly responds, "We may have expanded to a pressure dressing." But the reality, he admits, is that "in terms of the homelessness problem, the program is still a drop in the bucket. The potential is much greater than the actual impact."

"Maybe, though, it's the first domino, [because] we are making a difference on a small scale," he says. "The program is helping three of Philadelphia's shelters, and it is helping to change the health behaviors and lives of the patients, as well as the lives of Hahnemann's future physicians. It's an invaluable experience for everyone. And there's good in that."

WHAT'S BEING SAID ABOUT THE HAHNEMANN HOMELESS CLINICS

"You see homeless people in the news every night, but it doesn't hit you face-to-face until you visit the shelters. The homeless are appreciative of the time given to them."

John Williams
Second-year Hahnemann medical student and clinic volunteer

"You see more of the human factor working in the clinics than you do in medical school, which is all classroom right now...it's really interesting to talk to the patients, it's like a whole different life."

Timothy Reiter
Second-year Hahnemann medical student and clinic volunteer

"I really hope, once I become a doctor, that I keep the knowledge I have gained through this experience—that I realize it's not all money and that you need to donate your time."

Ashley Greenspun
Second-year Hahnemann medical student and clinic director

"When I worked in the clinic, the program had just started, and it was exciting. It was my first experience with clinical medicine, and it gave me an excellent sense of how to work with people and these types of patients in the hospital setting...It threw me right into inner-city medicine."

Mark V. Caliendo
Fourth-year Hahnemann medical student and State Society trustee

"I saw a lot as a student in that clinic [St. John's] that still helps me now."

Rick Anderson, MD
Co-founder of the Hahnemann Homeless Clinics

"The hands-on experience our students receive at the clinics is incredible and helps round out their education. Our volunteers learn about the underserved population, while attending to their health care needs...The kids have done a phenomenal job, and they've made a difference, there's no question about it."

Wilbur Oaks, MD
Professor of Medicine at Hahnemann

"The clinic has been invaluable. This year we didn't have nursing support at the shelter, and our residents were in real need of medical care. The Hahnemann students were there for us."

Amy Kaltenmark
Director of Project Home's Winter Emergency Shelter

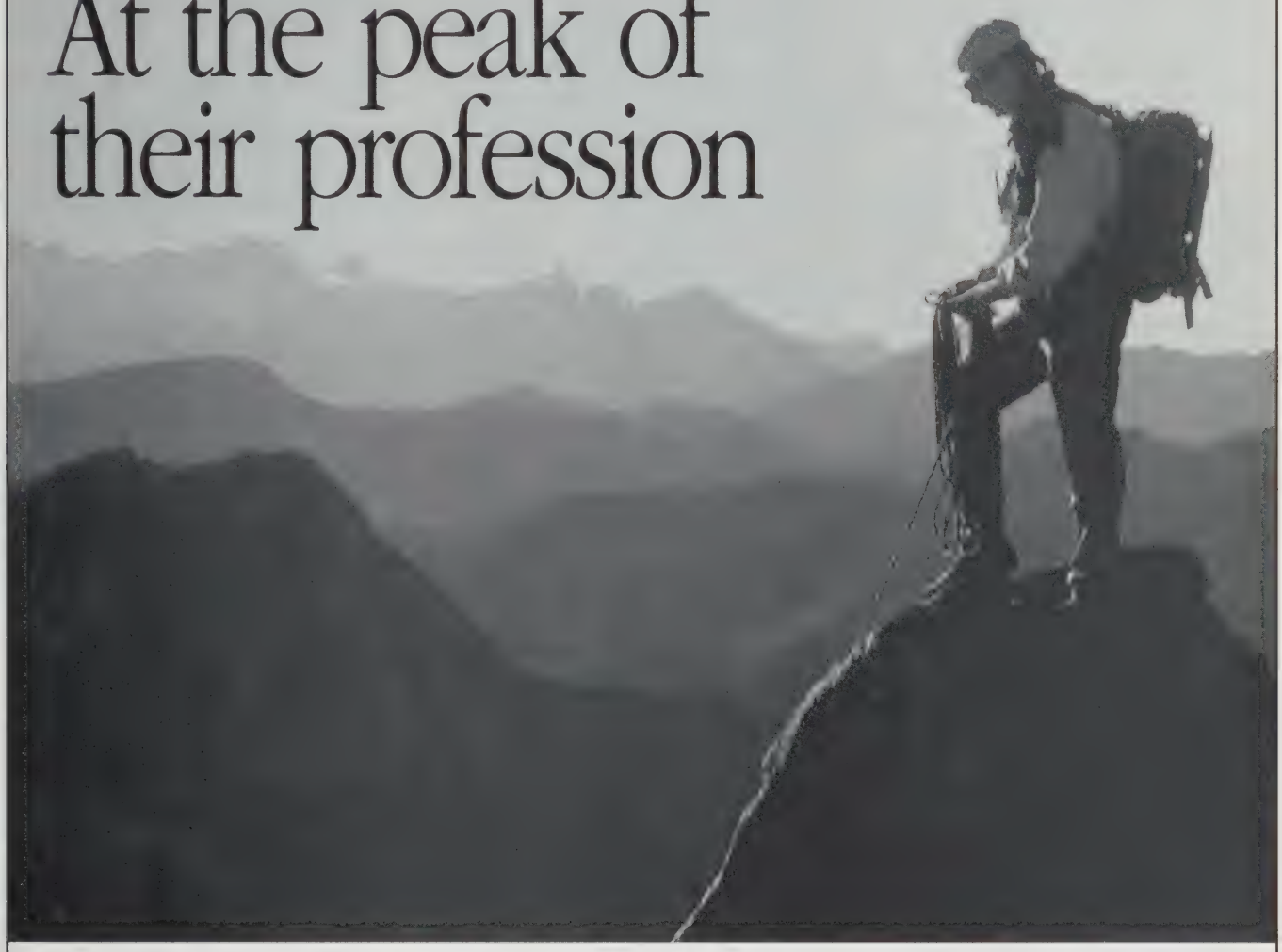
"Medical students like these who take time from their busy and hectic schedules to give of themselves, serving the homeless, are making a tremendous contribution to their communities. Providing health care to those who need it the most is one of the most serious public health concerns we have in this country. These men and women are part of the solution. I want to praise them and thank them for their efforts and commitment. I'm confident they'll look back on this experience during their medical school years as one of the most rewarding."

Allan S. Noonan, MD, MPH
Pennsylvania Secretary of Health

"As state and federal legislators continue to debate the best ways to expand access to quality medical services, Hahnemann medical students have confronted this problem at the most fundamental level by volunteering their time to provide for the public health. It has become a self-evident truth that Americans should have the right to basic health care, and the student volunteers work to make that right a reality for the homeless population in Philadelphia."

Harris Wofford
U.S. Senator

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AMA ADOPTS NINE MSS RESOLUTIONS

The AMA House of Delegates at its annual meeting in Chicago in June adopted nine of 11 resolutions sponsored by the AMA Medical Student Section (MSS).

Of the nine adopted resolutions, two were forwarded to the House requiring immediate action—both involved pending state and national legislation. The first directs the AMA to oppose the imposition of a selective revenue tax on health care providers by Congress and state legislatures to fund health care programs. Several states are currently considering or have already passed such legislation.

The second resolution directs the AMA to support federal action requiring rear and side impact guards on all new tractor trailers. The guards could prevent a number of fatalities each year caused when small passenger motor vehicles underride tractor trailers during traffic accidents. The National Highway Traffic Safety Administration of the Department of Transportation has similar legislation pending.

The House of Delegates also adopted a report examining trends in mortality and morbidity associated with abortions before and after the 1973 Supreme Court decision in *Roe v Wade*. Though some controversy arose, the delegates agreed the informational report did not diverge from the AMA's traditional non-position on abortion. It will be filed and disseminated to appropriate individuals, agencies, and groups.

Another report recommended amendments to the AMA Constitution and Bylaws regarding the MSS seat on the Board of Trustees. The amendments requested the right of the MSS to directly elect their trustee annually during the interim meeting. Previously, the board selected the student trustee from three names submitted by the MSS.

The amendments would also provide the medical student trustee with voting privileges on policy making issues, but not on intra-board elections or other board elections, selections, or nominations. These amendments were deferred for final action until the 1992 interim meeting.

James Brian
University of Pennsylvania
Philadelphia

TREATING FAMILY VIOLENCE

Violence among family members in the U.S. has now reached staggering proportions. Every year, more than two million cases of child abuse and neglect are reported, between two million and four million women are battered by their spouses, and as many as 1.1 million elderly are abused.

In the past, many physicians have felt uncomfortable dealing with domestic violence and consequently have been inadequate in that role. Much of this reluctance stems from the ethical and legal concerns that go along with identifying and counseling victims. In an effort to change past inadequacies in addressing domestic violence, the AMA has formed a National Coalition of Physicians Against Family Violence to involve physicians in activities that address the issue and better enable them to identify the symptoms firsthand.

In another effort, the AMA made "Treating Family Violence—Policy and Practice" the focus of educational seminars held during the AMA-MSS national convention in Chicago in June. Medical students participated in an informative discussion that identified the growing epidemic.

Students learned that while domestic violence is a growing public health problem, with increased awareness and involvement by physicians and medical students, many of the injuries that result from abuse can be prevented.

Anthony Spinola
University of Pittsburgh

AMA-MSS COUNCIL HOLDS FIRST MEETING

The newly elected AMA Medical Student Section Governing Council held its first meeting August 7-9 in Chicago to set goals for the council and MSS, appoint new leaders to MSS committees, and meet AMA staff and departments.

The council determined its long-term, short-term, and immediate goals using the Strategic Plan from the MSS Committee for Long Range Planning as a framework. Specific priorities for the long and short term include: increasing communication from leaders to members, as well as between chapters; increasing membership; expanding availability of legislative information and education, and developing a Legislative Action Committee; developing and promoting chapter and community projects; and training leadership.

The council acted quickly to carry out its objectives. Already, a Legislative Action Committee is in place to mobilize the nation's medical students when legislation on Capitol Hill requires an expedient and massive grassroots effort. Also, the council is appropriating more leadership responsibility and visibility for appointed MSS leaders, and a publication from the AMA-MSS about successful chapter and community projects is underway to guide future activity at medical schools across the nation.

In other business, the council assigned leaders from a nationwide pool of applicants to several MSS committees, such as the States Leadership Steering Committee, which manages chapters in seven distinct geographical regions; the Committee for Long Range Planning, whose main task will be to reform MSS election procedures; the Advisory Panel, whose research will be central to council reports on specific resolutions; the Computer Projects Committee, which promotes the use of computers in medicine and medical education; and the newly formed Legislative Action Committee.

Among appointed leaders is Amber Chatwin, Hahnemann University, who will chair Section Six—encompassing Pennsylvania, Delaware, the District of Columbia, Maryland, New Jersey, and Virginia—on the States Leadership Steering Committee.

Finally, members of the governing council met with members of AMA staff representing several departments to discuss MSS issues. For example, AMA's Membership Department is working to make membership more accessible to medical students with extended curricula, such as MD-PhD students, as well as to preserve membership through the transition to residency by offering multi-year discounts and benefits incentives.

The council will convene later this month for media training and to plan for the AMA's interim meeting in Nashville in December.

Maria Simbra
University of Pittsburgh
Member, AMA-MSS
Governing Council

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March 3, 1993

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Monitoring Impaired Physicians: A Tool for Relapse Prevention

Penelope P. Ziegler, MD

Physicians experience a broad spectrum of health problems which can disrupt their personal lives and impair their ability to function professionally. Some of these illnesses—such as alcoholism and other drug dependency, and certain psychiatric disorders—are chronic. While treatment usually results in remission of active symptoms, there is a risk of relapse if necessary steps are not followed. Therefore, the key to continued recovery and stable functioning lies in effective relapse prevention.

Monitoring has been shown to be an important component of relapse prevention for physicians in recovery from impairment.[1,2] Monitoring refers to the process of supervising and documenting the physician's participation in a structured plan of recovery activities.[3]

The Pennsylvania Medical Society, through The Educational and Scientific Trust, offers a variety of services under the Physicians' Health Programs (PHP). Pennsylvania physicians who are participants in PHP's monitoring program for impaired physicians enter into a "monitoring agreement." This agreement is individualized and specific to each participant's problems and needs. It is developed with input from the physician participant, the professional treatment provider(s), PHP staff, and, when indicated, other interested parties.

Elements of the monitoring agreement include:

• *A treatment plan*. This plan is specific to the participant's diagnosis and identified biopsychosocial needs. Treatment may begin in an inpatient, residential, or outpatient setting as indicated by appropriate level-of-care placement criteria. It may include individual and/or group therapy, family counseling, medication, detoxification, specialized testing, etc.

• *An assigned PHP monitor*. The monitor is a volunteer physician in the participant's home area who is often in recovery from a condition similar to that of the participant and who has been functioning well for several years. The monitor provides a role model and a sense of hope to the newly recovering physician, who may be struggling with devastating financial, legal, and emotional losses. The monitor offers support, direction, and encouragement, and also provides feedback to PHP about the participant's progress.

• *Abstinence*. Participants agree to abstain from the use of all brain-active substances, including alcohol, recreational drugs, and self-prescribed medications. If the participant develops a medical condition requiring the therapeutic use of such a substance (e.g., opiates for post-operative pain), the participant agrees to inform the treating physician of his/her history and to ask the treating physician to inform PHP when potentially high-risk drugs must be prescribed.

• *Analysis of body fluids*. Testing of urine, saliva, and/or blood for the presence of drugs is a helpful therapeutic adjunct in maintaining abstinence from mood-altering chemicals. Also, some psychiatrically ill physicians benefit from therapeutic monitoring of serum levels of prescribed psychoactive medications such as lithium carbonate and other mood stabilizers.

• *Attendance at mutual help meetings*. Utilization of 12-step programs—such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA), as well as other such groups—provides direction, structure, and support in maintaining stable recovery. Studies indicate that active participation in self-help groups enhances the likelihood of successful recovery and re-entry into medical practice.[4,5]

• *A personal physician*. Since drug dependence often begins in the context of self-treatment, it is essential that the recovering physician turn over his/her personal health care needs to an informed colleague. This should be a physician who is knowledgeable about the special issues facing persons in recovery from addictive



Dr. Zeigler is medical director of the Physicians' Health Programs of the State Society's Educational and Scientific Trust.

disease. The participant agrees to refrain from all self-prescribing since such behavior presents a significant relapse risk.

• *Advocacy*. When appropriate, other individuals and/or institutions can be involved in the communications network. In this way, PHP is able to provide progress reports and advocacy statements to the participant's hospital, group practice, professional liability carrier, and various governmental agencies (State Board of Medicine, Drug Enforcement Administration, etc.). Conversely, PHP encourages these other parties to maintain contact with PHP staff and express any concerns about the recovering physician's status immediately. This allows for early intervention in the event of a threatened or actual relapse.

The length of a participant's monitoring agreement varies, depending on the individual needs of the physician, the type of impairment, and the advocacy requirements. In most cases, an initial commitment of three years is suggested. However, both the length and the intensity of monitoring can be modified in response to the physician's progress in recovery. For example, as a participant demonstrates increased stability of function, the frequency of therapy appointments can be decreased. Alternatively, if a participant shows signs of resistance, denial, or impending relapse, the frequency of appointments, body fluids testing, and telephone contact can be increased.

Relapse of addictive or psychiatric disorders often can be predicted before the recovering person actually returns to chemical use or experiences a full blown episode of decompensation. Warning signs usually are present which, if recognized and responded to promptly, can prevent an actual recurrence of active disease. In fact, relapse is a dynamic process which is usually set in motion by a change in the individual's circumstances that increases perceived stress. The increased stress can lead to a return of denial, a shift in attitudes and behavior which draws the recovering person away from the path of recovery and back toward old patterns. For example, the recovering alcoholic in this type of situation may withdraw socially, become irritable, experience intense mood swings, etc. This is referred to as a "dry drunk."[6]

Some warning signs that a PHP participant may be moving toward a relapse include:

• *Noncompliance with the treatment plan*. Includes missed appointments, not attending AA or NA meetings, discontinuation of medication, not making scheduled telephone contacts.

• *Return of denial-based thinking and behavior*. For example, the physician minimizes the seriousness of past problems, rationalizes past drinking/drug use, or blames problems on spouse, family, partners, work schedule.

• *Substitute addictive behaviors*. These include compulsive overeating, gambling, shopping, and sexually acting out.[7]

If, despite monitoring and relapse prevention efforts, a relapse occurs, the participant's treatment plan must be revised to address the identified relapse triggers with the goal of re-establishing stable recovery and preventing future problems. The treatment provider(s), in consultation with PHP and other significant parties, should explore various questions with the participant about the relapse. For example, what were the warning signs that indicated the participant was headed for trouble? Were these signs recognized before the relapse by the therapist, by the staff? How were they responded to, and what was the participant's reaction?

In some cases, the relapse uncovers previously hidden issues—such as a co-existing psychiatric disorder, a family problem, or a shame-based secret—which need to be a focus of therapy. In other cases, persistent denial of the illness may be present in the physician or in significant others, such as family members, friends, partners, department heads, etc., which is undermining compliance with effective treatment and rehabilitation.

After a thorough re-evaluation has been conducted, a new treatment and monitoring plan will be developed. This may involve extended inpatient or residential treatment, intensive outpatient treatment, or additional modalities to address newly identified diagnoses, family dysfunction, etc. In many cases, the plan will need to address consequences which have resulted from the relapse, such as loss of employment, suspension of hospital privileges, marital discord, legal entanglements, and emotional reactions, including guilt, shame, and self-hatred. If the participant is cooperative and willing to follow through on the new recommendations, it is often possible for PHP to help the physician avoid some of these severe

"Relapse of addictive or psychiatric disorders often can be predicted before the recovering person actually returns to chemical use or experiences a full blown episode of decompensation."

consequences and continue or re-enter medical practice.

If a relapsing participant is not willing to cooperate with treatment or is unable to re-establish stable functioning, it may be necessary for PHP to refer the physician to the impairment consultant of the licensure board. The State Board of Medicine and the State Board of Osteopathic Medicine have designated PHP as their impaired professional program for physicians. Under this cooperative arrangement, most impairment cases can be handled in a therapeutic manner without formal prosecution. Disciplinary action is reserved for those physicians who do not cooperate with appropriate treatment and rehabilitation despite all efforts by PHP to engage them.

When impairing conditions are approached as medical illnesses requiring treatment and ongoing monitoring to achieve stable remission, the stigma and shame associated with these disorders is reduced. This encourages referral earlier in the course of the disease when the prognosis for recovery and re-entry into medical practice is favorable. The participant is encouraged to view PHP as "home base" and to work with program staff as part of a treatment team striving toward the common goals of stable recovery, professional re-entry, and personal satisfaction. Monitoring provides the structural framework around which the relapse prevention plan can be developed and implemented effectively.

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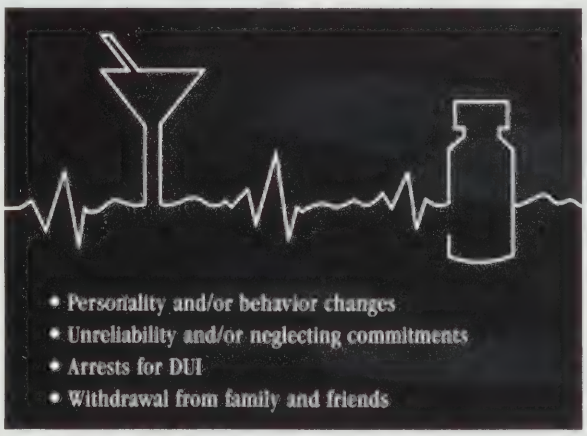
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HCFA AGREES TO CLIA EXTENSION

In response to lobbying by organized medicine, the Health Care Financing Administration (HCFA), agreed on August 31 to a 90-day extension on claims submission requirements for the implementation of the Clinical Laboratory Improvement Amendments (CLIA) of 1988.

Under terms of the extension, HCFA will not deny a Medicare claim for laboratory services submitted prior to December 1 for lack of a CLIA registration form or CLIA number. Physicians who have not already done so should use the 90-day period to submit their applications to HCFA and pay the registration fees. State Medicaid agencies were apprised of the HCFA extension and are expected to comply with the revised rules.

HCFA had been considering a six- to eight-week period but was not prepared to announce a "delay" in the effective date, due to the perceived congressional pressure for timely implementation of the regulations. When it became apparent that physicians were having difficulty registering with HCFA and getting their CLIA numbers, the American Medical Association (AMA) stepped up its lobbying activity to push for more time.

The 90-day extension follows a decision by Health and Human Services (HHS) Secretary Louis Sullivan, MD, that CLIA inspections of physician offices should be on an announced basis with three days' notice, rather than on an unannounced basis. In a letter to the AMA, Dr. Sullivan indicated that HHS is taking "great care to sensitize" the surveyors during their training about the importance of patient care in physicians' offices and of not disrupting the office by making extraordinary demands on the physicians. This decision was also a result of lobbying by the AMA and the State Society.

TUBERCULOSIS SPECTRE HAUNTS PUBLIC HEALTH

Although tuberculosis (TB) is both preventable and curable, it continues to be a public health problem in many cities and counties in Pennsylvania. From 1981 to 1986, the incidence of TB in the state decreased an average of 69 cases annually. In contrast, from 1986 to 1991, there has been an annual increase of 16 cases.

In 1991, 782 cases were reported in the state, or 6.6 cases per 100,000 people. That number is up two percent from the 767 cases reported in 1990. (For 1991 specifics by age and race/ethnicity, see Figure 1 below).

On a county level, Philadelphia reported 308 cases in 1991, compared to 253 cases in 1990, a 22 percent increase. Allegheny County reported 97 cases in 1991 and 78 cases in 1990, an increase of 24 percent. Pennsylvania's other 65 counties decreased from 436 cases in 1990 to 377 cases in 1991.

TB in children less than 15 years of age decreased from 29 cases in 1990 to 25 cases in 1991. Yet, since TB in children indicates recently acquired infection and transmission, these data are extremely important.

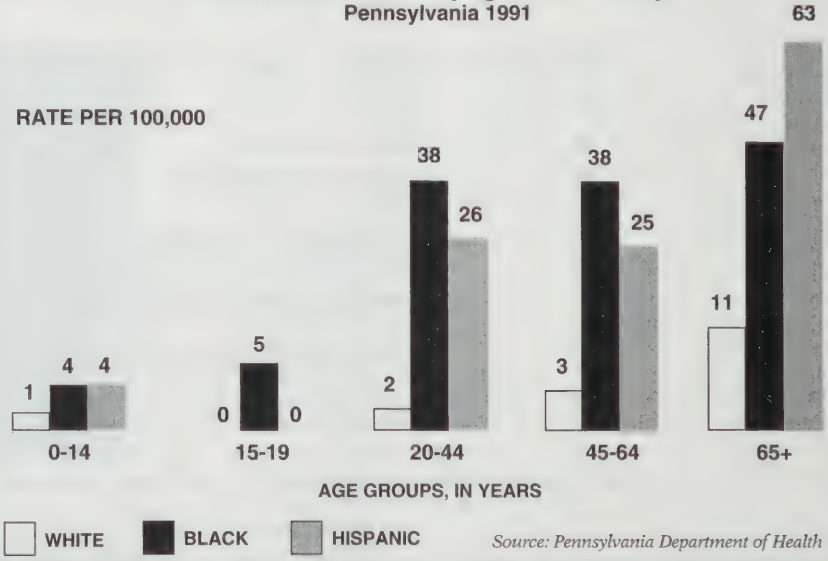
The incidence of TB is closely related to socioeconomic status, with the highest rates occurring among persons in low-income groups. Prevention and control efforts among lower socioeconomic groups present special problems because these groups usually have less access to care and less formal education, and are more likely to have coexisting diseases. Additional problems stem from a lack of shelter or transportation, higher rates of substance abuse, and more obstacles in complying with medical recommendations.

The Pennsylvania Department of Health's Tuberculosis Control Program has directed that all suspected or confirmed TB patients be assessed for the risk of acquisition of HIV infection. Since persons infected with both HIV and the tubercle bacillus are at high risk for severe clinical TB, and because the medical management of TB disease and infection must be altered in the presence of HIV infection, these cases are of particular public health concern. In 1991, 57 of the 782 state cases (7 percent) also had a diagnosis of AIDS. Of the 703 cases reported in 1986, only 6 (0.9 percent) also had AIDS.

There are wide variations in reports submitted to the Tuberculosis Control Program from around the state. Counties and districts should review their program reports to identify significant changes or deficiencies, investigate the cause of these, and implement local program changes. Elimination of TB will require coordinated efforts of public health agencies, voluntary health associations, and medical care providers.

From "Tuberculosis in the Commonwealth of Pennsylvania 1991," Tuberculosis Control Program, Pennsylvania Department of Health, May 1992

FIGURE 1
Rates of Tuberculosis by Age, Race/Ethnicity
Pennsylvania 1991



Source: Pennsylvania Department of Health

As seen in Figure 1, the highest rate of incidence of tuberculosis occurs in Pennsylvanians over the age of 65, regardless of race or ethnic background. According to the state's Department of Health, the incidence in that age group represents a decrease of one percent from 1990.



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Iris J. Bilker, *Wyncote*
Medical College of Pennsylvania, 1958; age 64, died July 15, 1992. Dr. Bilker was a psychiatrist.•

James T. Brennan, *Ambler*
University of Minnesota-Duluth School of Medicine, 1943; age 76, died July 5, 1992. Dr. Brennan was a therapeutic radiologist.•

Robert C. Frantz, *Wyomissing*
Jefferson Medical College, 1944; age 78, died August 7, 1992. Dr. Frantz specialized in occupational medicine.•

Frank J. Kanter, *Philadelphia*
Univ. Wien. Med. Fak, Wien, Austria, 1937; age 82, died July 10, 1992. Dr. Kanter specialized in aerospace medicine.•

Eugene R. Kutz, *Bedford*
Hahnemann University School of Medicine, 1945; age 70, died July 17, 1992. Dr. Kutz was a radiologist.•

Harry N. Rasansky, *Wynnewood*
University of Texas Southwestern Medical School at Dallas, 1948; age 72, died July 5, 1992. Dr. Rasansky was a family practitioner.•

Francis J. Schafer Jr., *Coraopolis*
Temple University School of Medicine, 1974; age 43, died June 8, 1992. Dr. Schafer specialized in infectious diseases.•

Richard A. Shields, *Philadelphia*
Duke University School of Medicine, 1940; age 77, died August 19, 1992. Dr. Shields was a general practitioner.•

Paschal Spagna, *Oreland*
University of Pennsylvania School of Medicine, 1960; age 57, died July 30, 1992. Dr. Spagna was a cardiovascular surgeon.•

Murray K. Spillman, *Lancaster*
Temple University School of Medicine, 1932; age 89, died December 22, 1992. Dr. Spillman specialized in pulmonary diseases.•

Harold A. Tattersall, *Cresco*
Jefferson Medical College, 1940; age 78, died July 6, 1992. Dr. Tattersall was a general practitioner.•

Thomas E. Timney, *Oil City*
Hahnemann University School of Medicine, 1937; age 81, died July 13, 1992. Dr. Timney was an ophthalmologist.•

Robert E. Barto, *Pittsburgh*
Jefferson Medical College, 1944; age 73, died July 24, 1992. Dr. Barto was a vascular surgeon.

John W. Crisanti, *Lock Haven*
Georgetown University School of Medicine, 1960; age 67, died June 20, 1992. Dr. Crisanti specialized in emergency medicine.

Richard G. Davis, *Elizabethtown*
University of Pennsylvania School of Medicine, 1953; age 67, died June 15, 1992. Dr. Davis was a dermatologist.

Philip L. DeLong, *Chalfont*
University of Pennsylvania School of Medicine, 1943; age 73, died May 8, 1992. Dr. DeLong was a family practitioner.

Wesley M. Evans, *Pittsburgh*
University of Pittsburgh School of Medicine, 1939; age 79, died May 23, 1992. Dr. Evans specialized in occupational medicine.

Catherine B. Hess, *Mechanicsburg*
Temple University School of Medicine. Age 76, died July 18, 1992. Dr. Hess was an adjunct professor in the Department of Humanistic Medicine at Penn State's Milton S. Hershey Medical Center.

Simon Levin, *Wallingford*
Temple University School of Medicine, 1952; age 66, died July 6, 1992. Dr. Levin was an obstetrician and gynecologist.

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KePRO's Community Outreach Programs

Donald E. Harrop, MD

The Keystone Peer Review Organization board of directors and management have always taken pride in knowing that individually and as a group they have put forth extra effort to assure maximum efficiency and fairness in the review system. Another source of pride to the organization is our Community Outreach Program which we think is one of the finest and most progressive in the country. While such a program is required under our contract with the Health Care Financing Administration (HCFA), we saw the need to go beyond the HCFA requirements.

Peer review organizations (PROs) are expected to have an 800 phone "hot line" to answer Medicare beneficiary questions about PRO review, handle problems with individual cases involving PRO denials, and investigate complaints about quality of care. If the calls do not involve one of these items, PROs are under no obligation to take any further action.

However, as might be expected, the Keystone Peer Review Organization (KePRO) gets calls related to a full range of problems with which the elderly must deal. Many times, these callers have made no progress by talking to numerous agencies and organizations to which they have been referred. Rather than add to their frustration, our philosophy for the hot line is that callers should not have to make more than one more call. That is, if the call is not relevant to KePRO, and if we can't answer their question or direct them appropriately at the time of their call, we will find the correct agency, and sometimes the specific person within the agency, for them to call.

We also have an obligation to meet with beneficiary groups to explain the PRO program and beneficiaries' rights under Medicare. During a recent 12-month period, KePRO personnel addressed 86 groups representing nearly 6,000 Medicare beneficiaries and/or their advocates. Recent efforts have been directed toward the education of the beneficiary advocates, since these are the people who are often turned to when the elderly need assistance.

HCFA regulations provide that each PRO board of directors must have representation by a consumer who is a Medicare beneficiary. When this was mandated, the KePRO board decided to go one step further and appoint a Consumer Advisory Committee comprised of nine Medicare beneficiaries and a representative of the Pennsylvania Department of Aging. The charge to the committee is to advise the board on the best and most effective methods of educating the elderly public about the program. I can truthfully say that this group has provided the board with numerous novel ideas and suggestions which have certainly enhanced our educational efforts.

There are, of course, other HCFA required activities, such as printing and distributing educational brochures and providing informational releases to the media. But again, because it seemed that all of these efforts did not reach enough of the population in a state as large as Pennsylvania, it was decided that an educational videotape would be a good tool for public education. HCFA had no interest in funding such a venture. Therefore, the Pennsylvania Medical Society's Educational and Scientific Trust obtained a grant from the Pew Foundation, and an excellent 11-minute tape was produced. The tape is made available to Area Agencies on Aging, television stations, and other groups who have an interest in the elderly population. One commercial station in Philadelphia recently used the tape as source material for a favorable news brief describing KePRO's role in assisting Medicare patients.

Our emphasis on the Community Outreach Program is a constant reminder of what the Medicare program is all about and for whom it was created: the beneficiaries—our patients.

Dr. Harrop is president of the Keystone Peer Review Organization.

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OPPOSITION TO RATIONING REVEALED IN POLL

Seventy-two percent of Pennsylvania residents would oppose rationing health care, according to a study by the Gallup Organization contracted by the Pennsylvania Medical Society. The 1992 Public Opinion Poll revealed that respondents under age 25 were more likely to favor rationing, and the uninsured and those without a personal physician were more likely to favor rationing than the insured or those with a physician.

The poll was primarily conducted to identify perceptions about the problems facing U.S. health care, to examine physician relationships, and to assess perceptions about health care costs. Questions addressed the cost of medical care, malpractice issues, health insurance coverage, and other topics. National comparisons are made using statistics from the 1992 Gallup Poll conducted for the AMA.

This article is a follow-up to "Survey Reveals Opinions on Health Care Issues," which appeared in the September issue of PENNSYLVANIA MEDICINE; it completes the summary of poll results.

Cost of medical care

Pennsylvania adults were asked: "Other than inflation, what do you think contributes most significantly to the cost of health care?" Top contributors listed by respondents include doctors' fees (26 percent), increases in technology costs (12 percent), hospital charges (10 percent), cost of medication (10 percent), and malpractice and lawsuits (8 percent).

Other results show that 57 percent of respondents would support a proposal to increase government spending to ensure access to care for the poor, even if it meant an increase in taxes; 59 percent were confident in their ability to pay for a major illness, a somewhat higher proportion than found nationally (55 percent); and 75 percent would be willing to pay more out-of-pocket for routine and less expensive care if they were confident that insurance would cover more expensive and long-term care.

Respondents were also asked to choose between several pairs of options regarding medical care. Their choices indicated they are more likely to:

- pay more and select a physician (83 percent), rather than pay less and have an assigned physician (15 percent);
- pay more and have an option on the hospital (80 percent), rather than pay less and be required to use a hospital selected by their insurance plan (17 percent);
- pay more and have care right away (74 percent), rather than pay less and have care delayed (22 percent);
- pay more and have technology available in their local community (55 percent), rather than pay less and have technology available only in regional centers (39 percent); and
- pay private doctors/hospitals (54 percent), rather than pay higher taxes for government care (41 percent).

Malpractice issues

In general, respondents believe the costs of malpractice suits need to be

FIGURE 1

Preferred Mechanism for Resolving a Complaint About a Doctor*

*Poll results are based on 408 interviews among adults in Pennsylvania in Spring 1992. The margin of error is 5 percent.

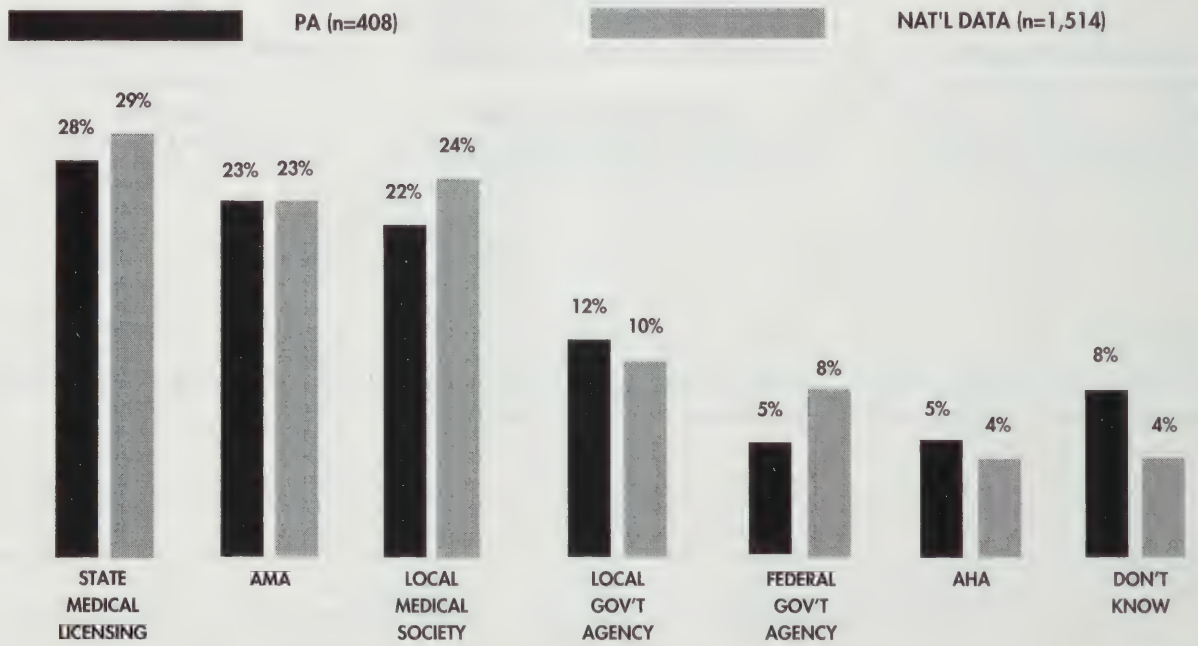


Figure 1 compares state and national responses to the 1992 Gallup Poll question: "Suppose you were dissatisfied with the way you were treated by a doctor and wanted to complain about it. If each of the following had a mechanism for resolving complaints about doctors, which *one* would you prefer to go to with your complaint?"

controlled. The majority of respondents (58 percent) felt that the number of malpractice suits against doctors was higher than justified, and 20 percent felt the number was about right. Also, 54 percent felt that too much money was being awarded in malpractice suits, 70 percent would favor setting a ceiling on pain and suffering awards, 68 percent felt malpractice suits have "a great deal" of effect on the cost of health care, and 77 percent would favor reducing malpractice awards if it would reduce costs.

The poll also asked: "Suppose you were dissatisfied with the way you were treated by a doctor and wanted to complain about it. If each of the following had a mechanism for resolving complaints about doctors, which one would you prefer to go to with your complaint?" The State Medical Licensing Board (26 percent), the American Medical Association (23 percent), and the local medical society (22 percent) were the preferred agencies (see Figure 1 for specifics and national comparison).

Health insurance coverage

Nearly nine in ten Pennsylvania residents (88 percent) are covered by some form of health insurance, according to the poll. That proportion is identical to the national figure.

Of those with insurance, 72 percent are covered through an employer, and 28 percent had health insurance through a government program, such as Medicare or Medicaid.

Further, 19 percent of respondents reported having had problems filling out insurance forms, and 65 percent agreed that Medicare patients should be charged for health services based on their ability to pay.

TRUST SPONSORING GRATEFUL MED® EXHIBIT

The Educational and Scientific Trust of the Pennsylvania Medical Society will sponsor an exhibit from the National Library of Medicine during the Society's annual business meeting at the Adams Mark Hotel, Philadelphia, October 22-25.

Attendees are invited to bring one or two questions they'd like to research in the National Library and have them answered free-of-charge through the on-line computer link known as GRATEFUL MED®.

GRATEFUL MED® is a menu-driven computer program provided by the National Library of Medicine which is available for both PCs and Macintosh computers. The software, when linked to the National Library by modem, permits individuals to search library files on demand. Bibliographies and abstracts are available on the screen and can be stored and/or reproduced on an office printer. The software also includes the LOANSOME DOC® ordering feature.

The Trust is sponsoring the exhibit to show physicians the ease with which research and patient support information can be obtained.

HAHNEMANN RECEIVES OUTREACH FUNDING

The Hahnemann University Library has been awarded $25,000 from the National Library of Medicine, Maryland, for a GRATEFUL MED® outreach project. GRATEFUL MED® is a computer program developed by the National Library to simplify on-line searching of the MEDLINE database; a recently added feature, LOANSOME DOC®, facilitates acquiring photocopies of articles.

The purpose of the project is to turn 200 health professionals who are minorities working in underserved urban areas, or who work with populations with high percentages of minorities, into active GRATEFUL MED® users. This will be accomplished through a combination of training, support services, and document delivery.

PITTSBURGH INITIATIVE GOES STATEWIDE

A Pittsburgh outreach initiative, supported by State Society involvement, is being expanded throughout Pennsylvania via public television stations this October during National Breast Cancer Month.

"The Breast Test"—a comprehensive project that provides women with practical information about breast cancer, self examination, and mammograms—is scheduled to be aired October 26 at 10:00 p.m. Funding will be provided by The Medical College of Pennsylvania and the Pennsylvania Public Television Network.

The model project, which was developed and tested in Pittsburgh by WQED-TV in 1991, included a television special; a viewer hotline; print and video resources; and outreach sites in a corporation, a public housing community, an African-American church, an elderly center, a women's group, and a neighborhood.

It was funded by the Jewish Healthcare Foundation with additional funding from the National Cancer Institute, and was the recipient of the American Cancer Society's award for "Best Public Awareness Campaign" and the Health Education Center's "Health Education/Media" award.

For additional information, check local listings. To receive a free copy of "The Breast Test" newsletter or an information packet on breast care, or to find out how to become involved, call (412) 622-6442.

County News

PHYSICIANS VOLUNTEER AT DELAWARE COUNTY CAMP

A number of Delaware County physicians volunteered their services on Sunday afternoons to provide medical exams to over 600 camp children throughout the summer.

For the fifty-eighth consecutive year, Camp Sunshine, located in Thornton, provided an overnight camp program for children from financially limited families in Delaware County. Ira H. Weiner, DO, has served as the "camp physician" for the past two summers, on call for medical situations that arise during the children's one-week camp stay. Several other county medical society members and area physicians assist the camp's administration each summer by performing "check-in physicals."

Specialty News

ORTHOPEDIC SOCIETY TO MEET IN NOVEMBER

The Pennsylvania Orthopedic Society will hold its fall meeting, "Orthopedic Update on Spine, Shoulder, and Elbow Surgery," November 12-14 at the Vista Hotel, Pittsburgh.

The meeting, which offers 12 Category 1 credit hours of continuing medical education (CME), will feature several national physicians:

- Neal S. El-Attrache, MD, Kerlan-Jobe Orthopedic Groups, Santa Monica, California, will present

"Elbow Arthroscopy" and "Medial Elbow Reconstruction in the Throwing Athlete."

• Richard J. Hawkins, MD, clinical professor, University of Colorado, and orthopedic surgeon, Steadman Hawkins Clinic, Vail, Colorado, will present "Update on Rotator Cuff Disease" and "Concepts of Instability."

• Harry N. Herkowitz, MD, chairman of orthopedic surgery and director of spine surgery, William Beaumont Hospital, Royal Oak, Michigan, will present "Surgical Treatment of Degenerative Lumbar Spondylolisthesis" and "The Role of Laminoplasty in the Management of Cervical Spondylosis."

• Michael R. Weitekamp, MD, associate professor of medicine, Penn State's Milton S. Hershey Medical Center, Hershey, Pennsylvania, will present "Update in Antibiotics for Orthopedics."

In addition to the scientific meeting, which runs from 1:00 p.m. on Thursday through 12:00 noon on Saturday, a Physician Leadership Workshop will be offered on Thursday from 8:00 a.m.-12:00 noon. The workshop, sponsored in conjunction with the Institute for Physician Leadership, will offer physicians in-depth training in communications and negotiations. It is approved for four Category 1 credit hours of CME.

For information or to register, call the orthopedic society at (717) 558-7750 or 1-800-228-7823.

AMA News

DOCTORS INVITED TO JOIN COALITION VS VIOLENCE

Concerned physicians across America are invited to join the National Coalition of Physicians Against Family Violence as one way of registering concern and willingness to help with the growing problem.

Upon joining, physicians will receive a set of guidelines on child physical abuse, child sexual abuse, and domestic violence which provide important information on diagnosis and treatment of abuse. Guidelines on elder abuse will be released later this fall.

To date, more than 1,200 individuals have joined the coalition. For information, call the AMA Department of Mental Health at (312) 464-5066.

PA AIDS ETC OFFERING HIV CLINICAL TRAINING

The Pennsylvania AIDS Education and Training Center (PA AIDS ETC) is offering a limited number of clinical mini-residency training programs for providers of direct patient care to HIV infected patients. The goal of the program is to increase the number of health professionals who are trained to care for HIV-infected and AIDS patients.

Qualified candidates may spend up to two days at a facility which provides specialized HIV care. Clinical settings for both pediatric and adolescent/adult care are available, and each candidate is matched with an expert clinical mentor at the facility which best meets the candidate's stated objectives.

Training is either one-on-one or small group, and rotations may include: multidisciplinary women's HIV service, laboratory medicine, pulmonary medicine, family medicine, inpatient and/or outpatient services, drug therapy and trials, dental medicine, pediatrics, private office, infectious diseases, and AIDS clinical research units.

PA AIDS ETC is one of a nationwide network of 17 centers established by the Health Resources and Services Administration, Bureau of Health Professions, Division of Medicine, U.S. Public Health Service, Department of Health and Human Services, to provide training for health professionals on HIV disease. PA AIDS ETC has 12 participating sites statewide, including sites in Hershey, Philadelphia, and Pittsburgh.

Continuing education credits and contact hours are available for clinical training participants. For additional information or to apply to the program, physicians in Philadelphia, Chester, Delaware, Bucks, and Montgomery counties should call Donna Donkockik at (215) 557-2101. Physicians in all other Pennsylvania counties should call Todd Harwell at (412) 624-1895.

INSTITUTE SEEKING FELLOWSHIP NOMINATIONS

The Institute of Medicine of the National Academy of Sciences is seeking nominations for the Robert Wood Johnson Foundation (RWJF) Health Policy Fellowships Program. The program, funded by RWJF and conducted by the institute with assistance from the American Political Science Association, is intended to provide opportunities for mid-career professionals working in academic settings to gain an understanding of major health policy issues and how they are addressed in the political system.

Six fellows participate annually in a one-year program of orientation and full-time working experience in Washington, DC. They are paid annual stipends with fringe benefits and are reimbursed for relocation expenses to and from Washington, within certain specified limits.

Nominations may be made by chief executive officers of eligible institutions, including all academic health centers and other institutions in the U.S. that have or are medical schools. Past fellows have been selected from faculty in medicine, dentistry, the biomedical sciences, nursing, public health, health services administration, the allied health professions, economics, and other social sciences.

For additional information, including nominee qualifications and a nomination timetable, call Marion Ein Lewin at the Institute of Medicine, (202) 334-1506.

CANCER PREVENTION TRIAL AT STATE SITES

Six Pennsylvania cancer facilities, along with more than 260 North American sites, are participating in the first nationwide trial to determine whether the drug, tamoxifen, prevents breast cancer.

Primary investigation sites in the state include: Fox Chase Cancer Center, Philadelphia; Delaware County Regional Cancer Center, Drexel Hill; Montgomery Cancer Center, Norristown; North Penn Cancer Program, Lansdale; Paoli Memorial Hospital, Paoli; and Saint Mary Regional Cancer Center, Langhorne. Research affiliates include: Polyclinic Regional Cancer Center, Harrisburg; and Reading Hospital Regional Cancer Center, Reading.

Tamoxifen is currently being used successfully to reduce tumor recurrence and improve survival rates in women with breast cancer, but previous studies have shown that the drug might be used to prevent the disease. Researchers also hope to

determine whether the drug reduces deaths from heart disease.

Approximately 16,000 women, 35 and older with certain risk factors, will be enrolled in the five-year study. They will take either tamoxifen or a placebo each day and be examined by a physician at regular intervals.

"Each year physicians find breast cancer in approximately 150,000 American women," says Mary Simmonds, MD, a cancer specialist and one of Polyclinic's principal investigators for the study. "If we prove tamoxifen prevents breast cancer, potentially we can save thousands of lives."

For additional information, call the National Cancer Institute's Cancer Information Service at 1-800-422-6237 or the American Cancer Society's Response System at 1-800-227-2345.

MCP AWARDED TWO-YEAR GRANT

The Medical College of Pennsylvania (MCP) was awarded a two-year, $134,000 grant from the Pew Charitable Trusts to fund the placement of 12 first-year medical students as interns in health and social service agencies in Germantown and East Falls.

The grant will promote a collaborative effort of faculty and students at the University of Pennsylvania, Jefferson Medical College of Thomas Jefferson University, and Hahnemann University School of Medicine. It will enable medical students at all the schools to develop coordinated outreach programs in their respective communities to address such problems as high infant mortality and inadequate prenatal care rates.

AMA News

AMA RELEASES UPDATED PHYSICIAN CODE OF ETHICS

The AMA's Council on Ethical and Judicial Affairs has released the 1992 edition of *Current Options*, the publication generally regarded as the medical profession's code of ethics. Newly published opinions include:

- rules generally prohibiting referrals to health care facilities in which referring physicians have financial interests;
- a provision that it is unethical for physicians to deny treatment to HIV-infected patients or to those who refuse HIV testing, unless knowledge of HIV status is necessary for proper care;
- guidelines for gifts from industry prohibiting physicians from accepting anything of substantial value, including travel and lodging expenses for educational and promotional events;
- identification of gender and racial disparities in medical care and research as significant health care problems;
- rules strictly forbidding sexual harassment and misconduct, including prohibiting sexual relations with patients;
- recognition of a physician's right to associate professionally with a chiropractor if believed by the physician to be in the patient's best interest; and
- rules for reporting impaired, incompetent, or unethical colleagues.

GENEVA INITIATIVE SEEKS MEDICAL BOOKS

The Geneva Initiative on Psychiatry is seeking books and periodicals for inclusion in four libraries being established as part of a reorganization of the psychiatric service in the Ukraine.

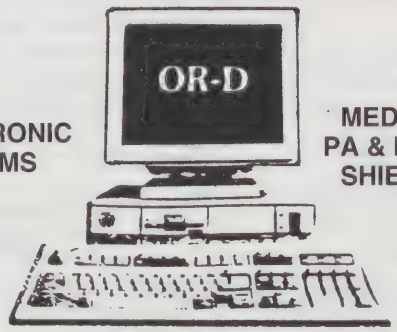
In cooperation with the new Ukranian Psychiatric Association, which has applied for membership in the World Psychiatric Association, a number of psychiatric manuals and textbooks will be published in Ukranian and Russian, and four psychiatric-medical libraries will be established in the Ukraine.

Physicians interested in helping may mail any quantity of books and periodicals, contemporary or outdated, regarding psychiatry and other medical science fields, to the Geneva Initiative Library Project, c/o Freedom House, 45 East 21st Street, 5th Floor, New York, NY 10010.

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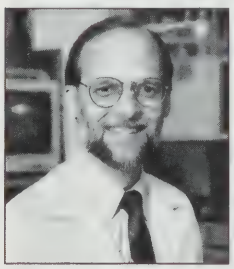
The late **Richard A. Kern, MD,** 1964 president of the State Society, has been honored by the installation of a plaque in the Scottish Rite Museum of National Heritage, Lexington, Massachusetts.

Margarita M. Torres, MD, Newtown, has been named medical director at Moss Rehabilitation Hospital, Philadelphia.

Ed Benz, MD, a native of Pittsburgh, has been named chairman of the Department of Medicine at the University of Pittsburgh School of Medicine.

Francis J. Duggan, MD, Hershey urologist, has been re-elected chairman of the board of directors of the Capital Area Health Foundation.

William G. Kussmaul III, MD, Media, has been appointed director of the Cardiac Catheterization Laboratory at Pennsylvania Hospital, Philadelphia.



Dr. Kussmaul

Edibaldo Silva, MD, PhD, FACS, Danville, has received a three-year appointment as cancer liaison physician for the Hospital Cancer Program, Geisinger Medical Center.

James J. Flowers, DO, had been named chairman, emergency services, Saint Agnes Medical Center, Philadelphia.

Richard Finegold, MD, urologist at the Monongahela Valley Hospital since 1972, received a Dimensions in Performance Award from the hospital for his outstanding accomplishments and dedication to the hospital and to health care.

Alan R. Silverman, MD, Pittsburgh, has been appointed to the board of directors of the American Society of Dermatopathology.

Bruce Kevin Branin, DO, vice president for medical services, Marworth Chemical Dependency Treatment Program, Geisinger Medical Center, Danville, was named to the board of directors of the American Society of Addiction Medicine.

Alan J. Wein, MD, chief, Division of Urology, University of Pennsylvania Medical Center, has received the Lifetime Achievement Award of the Urodynamics Society in recognition of significant contributions and leadership in the field of neurology.

Bryan C. Donohue, MD, cardiovascular disease specialist, Pittsburgh, was one of five U.S. physicians to visit Japan and Taiwan in June as part of a trip sponsored by the American College of Cardiology and the Fulbright Program of the United States Information Agency. Dr. Donohue lectured on advanced clinical strategies in management of acute ischemic heart diseases.

Albert Einstein Medical Center surgeons **Richard Greenberg, MD,** and **Mark Kaplan, MD,** have performed Philadelphia's first laparoscopic splenectomy.

Anthony V. Coletta, MD, associate attending surgeon, Bryn Mawr Hospital, has been accepted as a member of the Society of Laparoendoscopic Surgeons and of the International Society of Minimally Invasive Therapy.

Thomas Sedlacek, MD, chairman of the Department of Gynecology at The Graduate Hospital in Philadelphia, received the Colposcopy Recognition Award from the American Society for Colposcopy and Cervical Pathology for his exemplary pursuit of education in colposcopy, lower genital tract neoplasia, and related subjects.

John G. Case Jr., MD, Doylestown, was appointed medical director of Progressions, the partial hospital and outpatient services division of the Northwestern Institute, Fort Washington.

Valluvan Jeevanandam, MD, has been named surgical director of cardiopulmonary transplantation at Temple University Heart Failure and Transplant Center.

Alan M. Laties, MD, and **Richard A. Stone, MD,** professors in the Department of Ophthalmology of the University of Pennsylvania School of Medicine at Scheie Eye Institute, will share a $100,000 research award from Alcon Research Institute for outstanding contributions in the field of vision research.

Alan Richard Cohen, MD, Merion, was appointed division chief of hematology at The Children's Hospital, Philadelphia.

Fredric Jarrett, MD, Pittsburgh surgeon, was elected secretary of the Eastern Vascular Society.

Charles Fineberg, MD, professor of surgery and director of the operating rooms, Thomas Jefferson University Hospital, was elected president of the J. Aitken Meigs Medical Association.



Dr. Fineberg

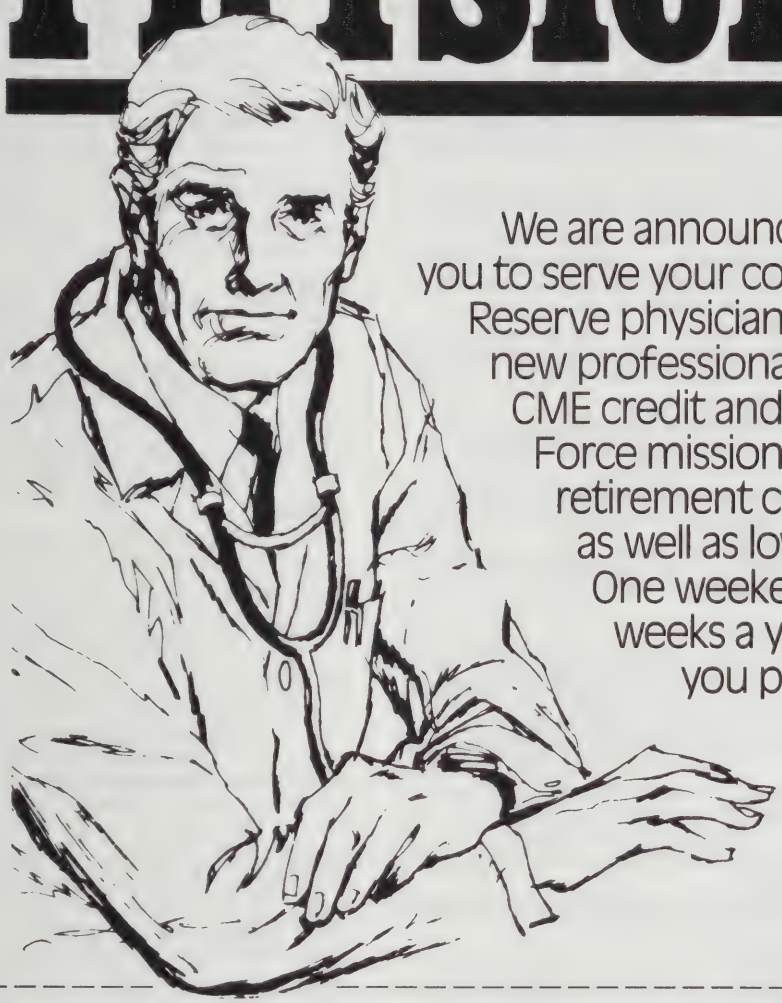
Howard McC. Snyder III, MD, associate director, Division of Pediatric Urology, The Children's Hospital, Philadelphia, was appointed to the board of directors of the National Kidney Foundation.

Sarah S. Long, MD, chief, Infectious Diseases Section, St. Christopher's Hospital for Children, Philadelphia, has been appointed chairman of the American Board of Pediatrics Subspecialty Board of Infectious Diseases. Also, **David S. Smith, MD,** a member of the hospital's Department of Pediatrics, was named Pediatrician of the Year by the Pennsylvania Chapter of the American Academy of Pediatrics. **William Hammer, MD,** chairman, Department of Medicine, Chestnut Hill Hospital, Philadelphia, has been elected president of the Philadelphia Academy of Cardiology.

Adam E. Flanders, MD, assistant professor of radiology, Jefferson Medical College, is one of six radiologists nationwide designated a 1992 Scholar of the Radiological Society of North America. The scholarship program supports the research of promising young academic radiologists.

Two physicians have been appointed to positions at The Graduate Hospital, Philadelphia: **Michael Baime, MD,** Media, as chief of the Division of Internal Medicine; and **Eliot Nierman, MD,** Philadelphia, as vice chairman of the Department of Medicine.

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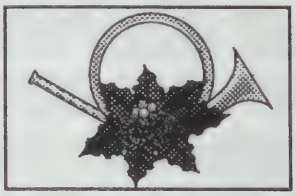
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AIR FORCE

Health Care: Noble Profession or Merely a Business Enterprise?

Narayan Deshmukh, MD

It is troubling to see the bureaucratic description of physicians as health care providers, no doubt invented to save the trouble of describing doctors, dentists, chiropractors, podiatrists, etc., separately, and to save on print.

While the description may be scientifically accurate, it detracts from the dignity of being addressed as a physician or doctor. Most physicians and nurses enter their profession for its nobility and the satisfaction it gives them to help their fellow human beings in their suffering. If it was merely a business to earn a livelihood, there are many other ways, perhaps less arduous and demanding, to make money.

When a patient walks into my office, I do not view him/her as another customer who will bring more dollars, but as a person with perhaps a challenging health problem which I want to solve and whom I want to restore to a normal state.

When a surgeon takes a certifying examination for the American Board of Surgery, the latter requires submission of all of the major operations done during the previous year along with their outcome. The physician is never asked how much money was brought in.

On the other hand, when Wall Street evaluates IBM, AT&T, or GM, the evaluation is based strictly on how many dollars they earned in the past year.

Similarly, it is inappropriate to refer to patients as clients. It has not been shown to decrease their sense of uncertainty or insecurity. If we are truly concerned about the dignity and feelings of our patients, let us address them politely by surname (instead of taking the liberty of calling them by their first names), treat them with greater compassion, and show an understanding of their difficulties. [Guthrie Clinic] does business with many companies and individuals that supply goods and services. That is a business-client relationship. Calling patients clients further confuses this relationship.

When a potential client walks into an automobile dealership, the salesman is interested in selling the most expensive car at the highest profit. When a patient enters a medical center, the last thing the health workers have on their minds is how much money this person is going to bring.

"There is no equivalent to the Hippocratic Oath or the Nightingale pledge for car salesmen, insurance agents, and retail chain managers."

As it is, the American public has become suspicious that the health profession is only interested in making the most money from patients, the government, and private health insurance companies. By addressing the patients as clients, we will further enhance this erroneous belief.

Most hospitals in this country are non-profit organizations, as is the Guthrie Clinic. Have you heard of any businesses that deal with clients being not-for-profit?

If we want to continue to have the medical and nursing professions treated as noble occupations and attract young people with high ideals, we should abandon this business approach of calling ourselves health care workers and the patients clients. There is no equivalent to the Hippocratic Oath or the Nightingale pledge for car salesmen, insurance agents, and retail chain managers.

Dr. Deshmukh is a general surgeon at the Guthrie Clinic Ltd., Sayre.

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The following is a brief summary only. Before prescribing, see complete prescribing information in Zantac® product labeling.

INDICATIONS AND USAGE: Zantac® is indicated in:
1. Short-term treatment of **active duodenal ulcer.** Most patients heal within 4 weeks.
2. **Maintenance therapy** for duodenal ulcer patients at reduced dosage after healing of acute ulcers.
3. The treatment of **pathological hypersecretory conditions** (e.g., Zollinger-Ellison syndrome and systemic mastocytosis).
4. Short-term treatment of **active, benign gastric ulcer.** Most patients heal within 6 weeks and the usefulness of further treatment has not been demonstrated.
5. Treatment of **gastroesophageal reflux disease (GERD).** Symptomatic relief commonly occurs within 1 or 2 weeks after starting therapy with Zantac 150 mg b.i.d.
6. Treatment of endoscopically diagnosed **erosive esophagitis.** Healing of endoscopically diagnosed erosive esophagitis occurs at 4 weeks (47%), 8 weeks (71%), and 12 weeks (84%) of therapy with Zantac 150 mg q.i.d. Symptomatic relief of heartburn commonly occurs within 24 hours of therapy initiation with Zantac.

Concomitant antacids should be given as needed for pain relief to patients with active duodenal ulcer; active, benign gastric ulcer; hypersecretory states; GERD; and erosive esophagitis.

CONTRAINDICATIONS: Zantac® is contraindicated for patients known to have hypersensitivity to the drug.

PRECAUTIONS: General: 1. Symptomatic response to Zantac® therapy does not preclude the presence of gastric malignancy.
2. Since Zantac is excreted primarily by the kidney, dosage should be adjusted in patients with impaired renal function (see DOSAGE AND ADMINISTRATION). Caution should be observed in patients with hepatic dysfunction since Zantac is metabolized in the liver.
Laboratory Tests: False-positive tests for urine protein with Multistix® may occur during Zantac therapy, and therefore testing with sulfosalicylic acid is recommended.
Drug Interactions: Although Zantac has been reported to bind weakly to cytochrome P-450 *in vitro*, recommended doses of the drug do not inhibit the action of the cytochrome P-450-linked oxygenase enzymes in the liver. However, there have been isolated reports of drug interactions that suggest that Zantac may affect the bioavailability of certain drugs by some mechanism as yet unidentified (e.g., a pH-dependent effect on absorption or a change in volume of distribution).

Increased or decreased prothrombin times have been reported during concurrent use of ranitidine and warfarin. However, in human pharmacokinetic studies with dosages of ranitidine up to 400 mg per day, no interaction occurred; ranitidine had no effect on warfarin clearance or prothrombin time. The possibility of an interaction with warfarin at dosages of ranitidine higher than 400 mg per day has not been investigated.
Carcinogenesis, Mutagenesis, Impairment of Fertility: There was no indication of tumorigenic or carcinogenic effects in life-span studies in mice and rats at dosages up to 2,000 mg/kg per day.

Ranitidine was not mutagenic in standard bacterial tests (*Salmonella, Escherichia coli*) for mutagenicity at concentrations up to the maximum recommended for these assays.

In a dominant lethal assay, a single oral dose of 1,000 mg/kg to male rats was without effect on the outcome of two matings per week for the next 9 weeks.
Pregnancy: ***Teratogenic Effects: Pregnancy Category B:*** Reproduction studies have been performed in rats and rabbits at doses up to 160 times the human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Zantac. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.
Nursing Mothers: Zantac is secreted in human milk. Caution should be exercised when Zantac is administered to a nursing mother.
Pediatric Use: Safety and effectiveness in children have not been established.
Use in Elderly Patients: Ulcer healing rates in elderly patients (65-82 years of age) were no different from those in younger age-groups. The incidence rates for adverse events and laboratory abnormalities were also not different from those seen in other age-groups.

ADVERSE REACTIONS: The following have been reported as events in clinical trials or in the routine management of patients treated with Zantac®. The relationship to Zantac therapy has been unclear in many cases. Headache, sometimes severe, seems to be related to Zantac administration.
Central Nervous System: Rarely, malaise, dizziness, somnolence, insomnia, and vertigo. Rare cases of reversible mental confusion, agitation, depression, and hallucinations have been reported, predominantly in severely ill elderly patients. Rare cases of reversible blurred vision suggestive of a change in accommodation have been reported. Rare reports of reversible involuntary motor disturbances have been received.
Cardiovascular: As with other H_2-blockers, rare reports of arrhythmias such as tachycardia, bradycardia, atrioventricular block, and premature ventricular beats.
Gastrointestinal: Constipation, diarrhea, nausea/vomiting, abdominal discomfort/pain, and rare reports of pancreatitis.
Hepatic: In normal volunteers, SGPT values were increased to at least twice the pretreatment levels in 6 of 12 subjects receiving 100 mg q.i.d. intravenously for 7 days, and in 4 of 24 subjects receiving 50 mg q.i.d. intravenously for 5 days. There have been occasional reports of hepatitis, hepatocellular or hepatocanalicular or mixed, with or without jaundice. In such circumstances, ranitidine should be immediately discontinued. These events are usually reversible, but in exceedingly rare circumstances death has occurred.
Musculoskeletal: Rare reports of arthralgias.
Hematologic: Blood count changes (leukopenia, granulocytopenia, and thrombocytopenia) have occurred in a few patients. These were usually reversible. Rare cases of agranulocytosis, pancytopenia, sometimes with marrow hypoplasia, and aplastic anemia and exceedingly rare cases of acquired immune hemolytic anemia have been reported.
Endocrine: Controlled studies in animals and man have shown no stimulation of any pituitary hormone by Zantac and no antiandrogenic activity, and cimetidine-induced gynecomastia and impotence in hypersecretory patients have resolved when Zantac has been substituted. However, occasional cases of gynecomastia, impotence, and loss of libido have been reported in male patients receiving Zantac, but the incidence did not differ from that in the general population.
Integumentary: Rash, including rare cases suggestive of mild erythema multiforme, and, rarely, alopecia.
Other: Rare cases of hypersensitivity reactions (e.g., bronchospasm, fever, rash, eosinophilia), anaphylaxis, angioneurotic edema, and small increases in serum creatinine.

OVERDOSAGE: Information concerning possible overdosage and its treatment appears in the full prescribing information.

DOSAGE AND ADMINISTRATION: (See complete prescribing information in Zantac® product labeling.)
Active Duodenal Ulcer: The current recommended adult oral dosage is 150 mg or 10 mL (2 teaspoonfuls equivalent to 150 mg of ranitidine) twice daily. An alternative dosage of 300 mg or 20 mL (4 teaspoonfuls equivalent to 300 mg of ranitidine) once daily at bedtime can be used for patients in whom dosing convenience is important. The advantages of one treatment regimen compared to the other in a particular patient population have yet to be demonstrated.
Maintenance Therapy: The current recommended adult oral dosage is 150 mg or 10 mL (2 teaspoonfuls equivalent to 150 mg of ranitidine) at bedtime.
Pathological Hypersecretory Conditions (such as Zollinger-Ellison syndrome): The current recommended adult oral dosage is 150 mg or 10 mL (2 teaspoonfuls equivalent to 150 mg of ranitidine) twice a day. In some patients it may be necessary to administer Zantac® 150-mg doses more frequently. Dosages should be adjusted to individual patient needs, and should continue as long as clinically indicated. Dosages up to 6 g per day have been employed in patients with severe disease.
Benign Gastric Ulcer: The current recommended adult oral dosage is 150 mg or 10 mL (2 teaspoonfuls equivalent to 150 mg of ranitidine) twice a day.
GERD: The current recommended adult oral dosage is 150 mg or 10 mL (2 teaspoonfuls equivalent to 150 mg of ranitidine) twice a day.
Erosive Esophagitis: The current recommended adult oral dosage is 150 mg or 10 mL (2 teaspoonfuls equivalent to 150 mg of ranitidine) four times a day.
Dosage Adjustment for Patients With Impaired Renal Function: On the basis of experience with a group of subjects with severely impaired renal function treated with Zantac, the recommended dosage in patients with a creatinine clearance less than 50 mL per minute is 150 mg or 10 mL (2 teaspoonfuls equivalent to 150 mg of ranitidine) every 24 hours. Should the patient's condition require, the frequency of dosing may be increased to every 12 hours or even further with caution. Hemodialysis reduces the level of circulating ranitidine. Ideally, the dosing schedule should be adjusted so that the timing of a scheduled dose coincides with the end of hemodialysis.

HOW SUPPLIED: Zantac® 150 Tablets (ranitidine HCl equivalent to 150 mg of ranitidine) are peach, film-coated, five-sided tablets embossed with "ZANTAC 150" on one side and "Glaxo" on the other. They are available in bottles of 60 (NDC 0173-0344-42) and 100 (NDC 0173-0344-09) tablets and unit dose packs of 100 (NDC 0173-0344-47) tablets.

Zantac® 300 Tablets (ranitidine HCl equivalent to 300 mg of ranitidine) are yellow, film-coated, capsule-shaped tablets embossed with "ZANTAC 300" on one side and "Glaxo" on the other. They are available in bottles of 30 (NDC 0173-0393-40) tablets and unit dose packs of 100 (NDC 0173-0393-47) tablets.

Store between 15° and 30°C (59° and 86°F) in a dry place. Protect from light. Replace cap securely after each opening.

Zantac® Syrup, a clear, peppermint-flavored liquid, contains 16.8 mg of ranitidine HCl equivalent to 15 mg of ranitidine per 1 mL in bottles of 16 fluid ounces (one pint) (NDC 0173-0383-54).

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May 1992
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NOVEMBER 1992

Issues Before the State Society This Fall

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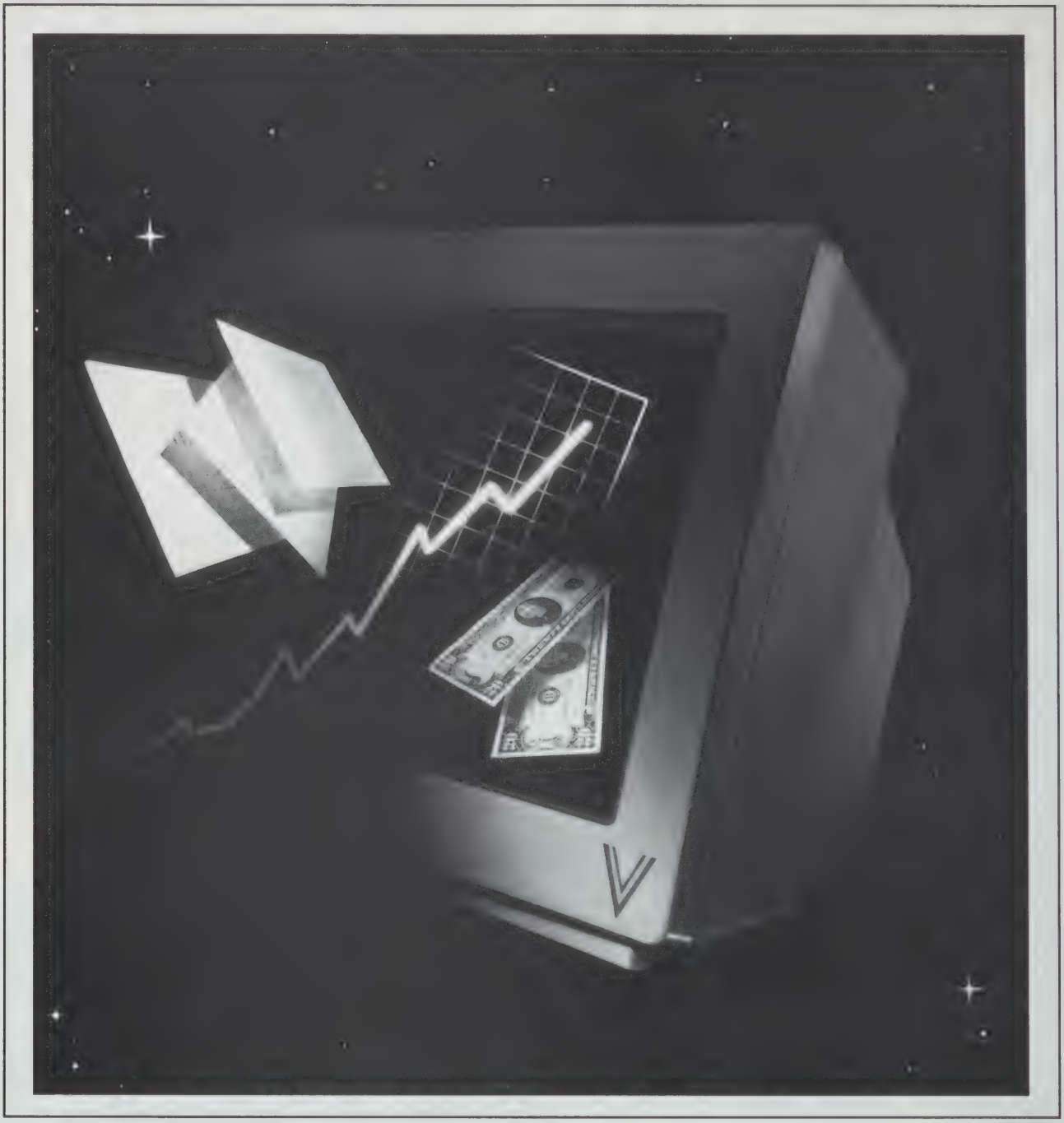
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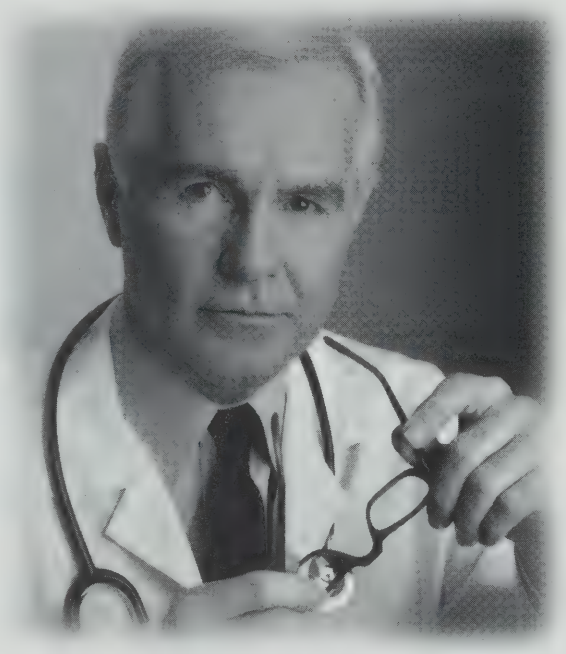
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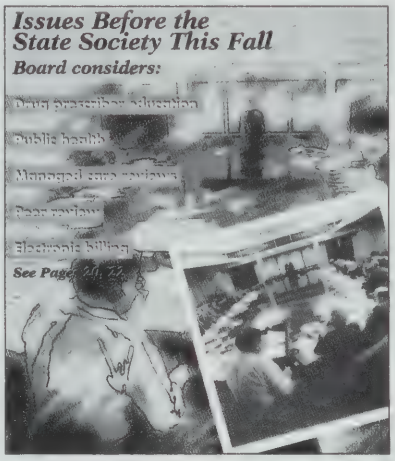
12 DER Revises Waste Management Rules



A number of improvements have been made in new Department of Environmental Resources regulations to help physicians manage infectious wastes more easily. This article summarizes those improvements.

20 Actions of the Board of Trustees, September 9, 1992

The Society's Board of Trustees is charged to discuss and take action on medical issues, ranging from public health and health care legislation to medical economics and electronic billing. Overviewed in this months' "Policy Briefs" section are actions from the Society's September board meeting.



(Insert) 24 What Have You Done for Me Lately?

The value of membership in your county society, the State Society, and the AMA is evident in several areas, such as in how you practice, in education, on Capitol Hill, and in your community. This special insert outlines what organized medicine "has done for you lately" in these areas and more.



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PENNSYLVANIA MEDICINE (ISSN 0031-4595) is published monthly by the Pennsylvania Medical Society, 777 East Park Drive, Harrisburg, PA 17111.
SUBSCRIPTIONS: $20 per year— United States and Canada; $30—all others. Single issues $3.00 per copy prepaid; special issues cost more.
POSTMASTER: Send address changes to PENNSYLVANIA MEDICINE, 777 East Park Drive, PO Box 8820, Harrisburg, PA 17105–8820. Second class postage paid at Harrisburg, PA 17105.



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MEDIGRAM

WORKERS' COMP RATES INCREASED, LEGISLATIVE CONTACTS NEEDED: While the governor and General Assembly remained deadlocked over legislation to reform workers' compensation, the Insurance Department on October 21 approved a 24 percent increase in workers' compensation insurance rates. Though the increase does not impact medicine, passage of House Bill 2 or House Bill 2140 would. The Society is supporting the Senate-amended version of House Bill 2140 which reimburses providers at 120 percent of the Medicare allowance for the remainder of 1992 and offers an annual update beginning in 1993 equal to the percentage change in the statewide average weekly wage. House Bill 2 permanently ties reimbursement to 117 percent of Medicare. PHYSICIANS ARE URGED TO CONTACT THEIR LEGISLATORS IMMEDIATELY TO SUPPORT HOUSE BILL 2140 (PRINTER'S NUMBER 3913).

SOCIETY DUES UNCHANGED FOR 1993: At its annual meeting in October, the Society's House of Delegates set 1993 Society dues at $430 for each full member, the same as in 1992. As in the past, $10 of that assessment will be given to the Society's Educational and Scientific Trust. Dues for other categories of membership are also unchanged.

SOCIETY NEGOTIATES PROPOSED 91 PERCENT CAT FUND FOR 1993: The State Society has again won substantial savings for Pennsylvania physicians by negotiating that the proposed physician CAT Fund for 1993 be set at 91 percent; it was originally proposed at 93 percent. The percentage is a surcharge to basic malpractice premiums and serves as insurance above the amount covered under basic plans. The two percent difference means an overall savings of approximately $3.6 million statewide. The Insurance Department approved percentage for 1992 was 90 percent. Final approval for 1993 is pending.

CHILDHOOD IMMUNIZATION INSURANCE ACT EFFECTIVE THIS MONTH: Act 35 of 1992, the Childhood Immunization Insurance Act, becomes effective November 21. The act mandates insurance coverage for childhood immunizations, including first-dollar coverage for all vaccines and professional fees to administer them. However, insurance coverage is *not* provided for the office visit or diagnostic laboratory tests unless preventive care and routine office visits are part of a company's medical insurance coverage. Deductibles and dollar limits may *not* apply to the immunization services. The Society and the Pennsylvania Chapter of the American Academy of Pediatrics cooperated in obtaining passage of this legislation.

IMMUNIZATION PROJECT KICKS OFF NOVEMBER 19 AND 20: The State Society, the Department of Aging, the Philadelphia Department of Public Health, the Philadelphia County Medical Society, and other organizations will kick off a joint immunization project November 19 and 20 at the North Broad Street Senior Center, Philadelphia. Several physician volunteers have already signed up through Project PA, the Society's referral network of physician volunteers. The project will continue on a quarterly basis for the next year and a half. For information, call the Department of Hospital Relations at 1-800-228-7823.

SOCIETY, PBA JOINING ON CHILD ABUSE PROJECT: The State Society is joining with the Pennsylvania Bar Association (PBA) to bring about public awareness of child abuse and give Pennsylvanians information on where to go for help. A program, being built around the PBA-funded video, "Children of the Lie," is tentatively scheduled to air on the Pennsylvania Public Television Network (PPTN) in early January. Watch this publication for further information.

AMA DELEGATE MEETING SLATED FOR DECEMBER: The interim meeting of the AMA House of Delegates will take place December 6-9 in Nashville, Tennessee. Pennsylvania delegates will present 15 resolutions addressing health care reform, AIDS, medical school loan interest, and other issues.

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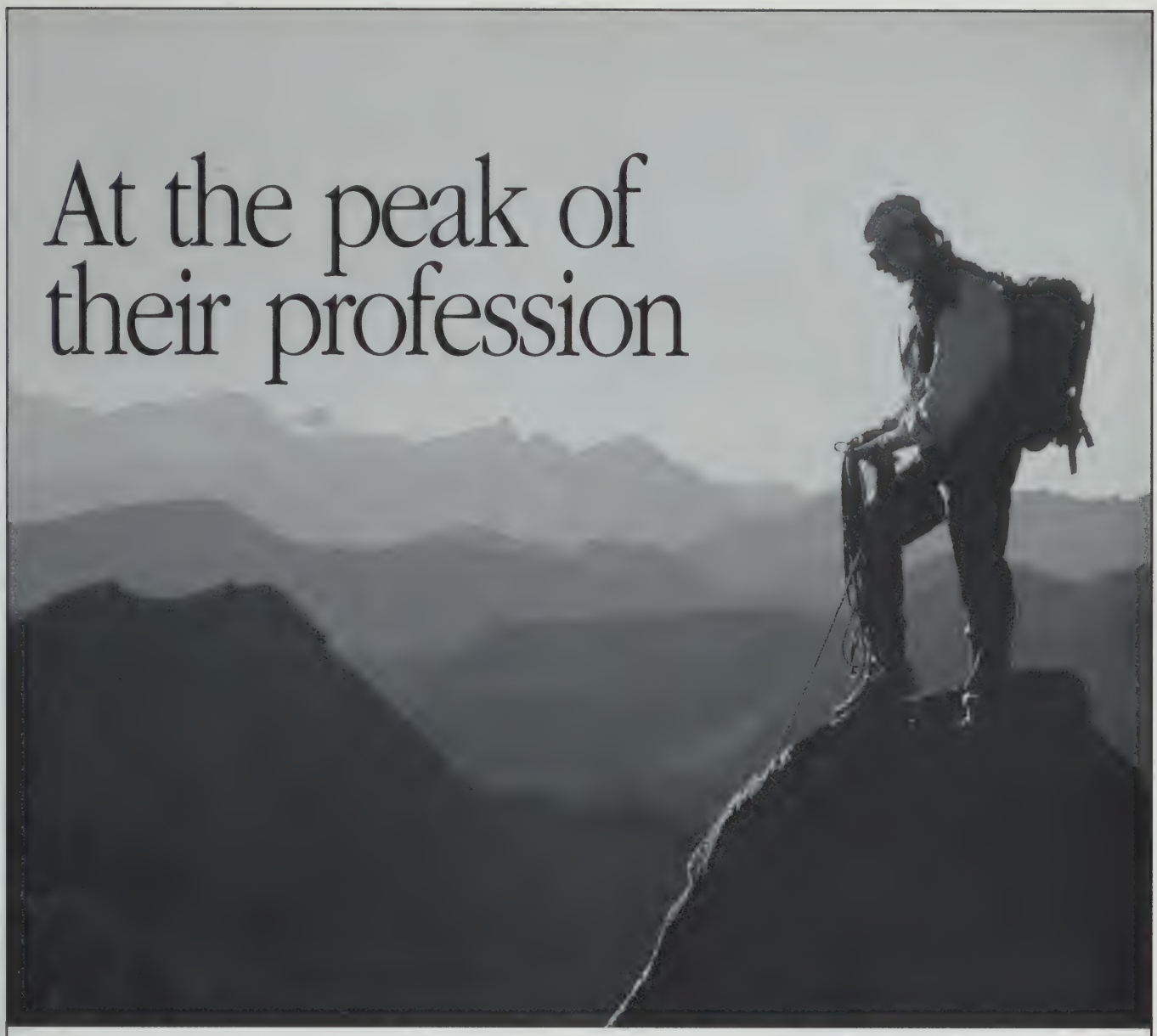
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Is Anyone Out There?

John W. Mills, MD
Medical Editor

Apathy at the county medical society level is on the increase. I don't think anyone would argue that point. Perhaps it is more widespread than that, but as a district trustee, I see and experience it first-hand.

To say the least, it's very discouraging. Not that my district is unique. Allegheny County, with about 3,000 members, may only get 100 out to a county society meeting. Indiana County, on the other hand, may see up to 25 members out of 87 at a meeting. Not bad, you say!

However, the problem goes deeper than members attending a county society meeting. It's the CME credit and pharmaceutical-sponsored program/meal that accounts for our good turnout. Try to get members to serve as officers, delegates to the House, etc., and you get a myriad of excuses. Many of these are legitimate, and I understand and appreciate these reasons.

"Members who care about these problems and have ideas to help solve them are urged to communicate with us. . ."

With unification, it should be obvious to any physician that whatever the AMA does nationally or the Pennsylvania Medical Society does statewide, all members and non-members alike are affected by the outcomes. So, whether a physician belongs and is active, belongs and is inactive, or doesn't belong at all, the benefits and the losses that organized medicine has orchestrated are shared equally by all of us. But even this reality doesn't help motivate our constituents to join or become more active.

It's also an accepted fact that you get as much out of an organization as you put into it. This may not be quite as evident in our scenario, but subtly, I believe it's true. There is personal growth, along with increased awareness and knowledge. Certainly, there is satisfaction in helping to guide and promote an organization that exclusively serves the medical "fraternity/sorority" to the best of its ability.

As I indicated in a recent editorial, we frequently have trouble filling leadership slots at the state level and certainly at the county level. Reimbursement for all six counties in my district is the lowest level—area IV. Thus, the average physician in this area has to see more patients and work longer hours than his/her cohorts in areas I, II, and III to make an equal living. I hear this when I ask colleagues to serve. When they tally it up—four to eight meetings a year out of town, with at least an additional day of travel (round trip), means a week or two out of practice—some can't afford it. Are their priorities wrong? Who am I to judge?

Your trustees recently voted to explore the idea of having board meetings in district settings, and perhaps regional district meetings, in an attempt to get closer to our grassroots membership. I believe this has merit. Local or regional meetings may serve to educate members as to what we really are all about and offer them a genuine way to participate with a minimal effort on their part.

One aspect of this issue, which I am calling apathy, has to do with family—especially for young physicians. They want to spend more time with their families, and I can't criticize that. Even if they strongly favor organized medicine, their practices and families come first—and that's the way it should be. I remember those days only too well, and realize that I really didn't know my oldest two children nearly as well as my younger two.

I don't have any answers to the dilemmas I have pointed to here. I only hope that the State Society's efforts to remedy them are fruitful. Members who care about these problems and have ideas to help solve them are urged to communicate with us—either a district trustee, the State Society, or this publication.

Physicians are all strong individualists, and each one has to decide how to partition his or her time between practice, family, leisure, and other activities, including community affairs and medical society involvement. Discouraged by this apathy as I am, I'll run for re-election as Ninth District Trustee, even though Indiana County will not be sending any delegates to the annual meeting.



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Unity and Unanimity

Donald G. Ferguson, MD

Editor's Note: The October issue of PENNSYLVANIA MEDICINE featured Donald G. Ferguson, MD, who was inaugurated as the Society's 143rd president during the House of Delegates' Annual Meeting in October. This is Dr. Ferguson's first "President's Page."

We are hearing a lot about unity and disunity in our profession nowadays. We are being told, in the words of John J. Ring, MD, recent president of the American Medical Association, that we must take part—or be taken apart.

We are also being told that we are not holding together as a profession, that we are becoming fragmented and disunited, and that this disunity will be our downfall. Some see us as moving together; others see us inevitably moving apart. Which of these viewpoints is correct? I submit that both may be.

Unity does not mean unanimity. We can, and inevitably will, disagree among ourselves. One specialty may very well want something that another specialty does not, or that another specialty wants for itself—turf battles, if you will. These differences are real, and their solutions are sometimes difficult.



Certainly, our profession is becoming increasingly complex. As specialized knowledge accumulates, it is increasingly obvious that no one person can learn all the skills of modern medicine in any great depth. No one can stay current in all fields, especially those surgical and dexterous pursuits that not only require knowledge, but continuing experience, to maintain that unthinking smoothness of motion and of thought that is the mark of the true craftsperson in any field.

We can, and should, speak out for ourselves as the possessors of specialized knowledge in medicine. We should also work, and when necessary, fight to establish our own unique place as specialists in the mainstream of American medicine.

But we also can and must speak and work for all of medicine. We must be part of a united profession in the face of those who seek to divide us so that they may rule us—and our profession.

A lot of people are out there trying to divide us and hoping to rule us (starting with some in the government of our own commonwealth). To answer those who would divide us, we must speak up so that we are heard as one voice—speaking for ourselves, our profession, and above all the well-being of our patients.

"What is that one voice, without which we truly are disunited and vulnerable to professional disintegration and anarchy? I submit that it is the Pennsylvania Medical Society and on the national level, the American Medical Association."

What is that one voice, without which we truly are disunited and vulnerable to professional disintegration and anarchy? I submit that it is the Pennsylvania Medical Society and, on the national level, the American Medical Association.

As your new president, I am mindful and deeply respectful of the work of specialty organizations that have served their physicians well—on occasion far better than we more inclusive organizations have been able to on issues that cut through and divide our diverse membership.

There is a place for diversity. But there is also a place—many places—for unity. I ask you to join me this year in a unified Society, particularly in the capitals of our state and of our nation.



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LETTERS TO THE EDITOR

READER TROUBLED BY "REFRESHING VIEW"

I am writing to comment on Leslie E. Morris, MD's, "A Refreshing View: The Oath of Hippocrates," in the July 1992 PENNSYLVANIA MEDICINE.

I am troubled that he quotes the phrase from the oath, "I will not give to a woman a pessary to produce an abortion," as if it were a sentence complete in itself, and worse yet, as if it were a paragraph in itself. Were this the case his comments would be apropos.

The phrase in question is the last part of a sentence which is, in turn, the last sentence in the paragraph he quotes immediately beforehand. The phrase proscribing abortion is one of a piece with the oath to follow "that system of regimen which, according to my ability and judgment, I consider for the benefit of my patients and [will] abstain from whatever is deleterious and mischievous."

The part of the sentence which Dr. Morris did not quote reads, "I will give no deadly medicine to anyone if asked, nor suggest any such counsel, *and in like manner* I will not give to a woman a pessary to produce an abortion." The latter phrase dealing with abortion is inextricably linked to the phrase prohibiting helping someone kill themselves, or even suggesting such a course. The key thought is that the physician is to entirely avoid any activities which end a human life.

As Dr. Morris stated, in ancient times abortion may have had a mortality of 50-60 percent to the mother, although this is a claim without any available historic data to support it. Of greater pertinence, from the point of view of the Oath of Hippocrates, is that abortion generally has a 100 percent mortality rate for the developing baby. Hippocrates prohibited abortion because it *always* ends a human life.

Hippocrates' proscription of abortion was a radical step for its time. He lived in an age when not only abortion was "legal," but also leaving unwanted children outside to die of exposure, thirst, or wild animals was an accepted part of that particular culture. It is only in the last 20 or so years since *Roe v. Wade* that physicians in this country have had trouble comprehending that Hippocrates really meant what he said.

Lastly, a hypothetical situation concerning a 14-year-old girl who is pregnant by rape is posed. The question is raised as to whether Hippocrates would deny such a person an abortion with the implicit reply that he, of course, would not. The phrasing of the situation implies that rape of 14-year-old girls and unwanted pregnancies were a problem unknown to the ancient Greeks. One need not delve very far into the classic writings of that age to discover otherwise. This makes the position which Hippocrates stated concerning abortion all the more astonishing in its respect for and protection of life within the womb.

Yes, much of the Oath of Hippocrates is archaic, paternalistic, sexist, anachronistic, and pantheistic. The paragraph prohibiting involvement in abortions is sadly now an anachronism, but that has only been by willful intent and not by any new discovery in human biology. Rather, what we now know concerning the development of a distinct human individual with his or her own set of unique chromosomes and behaviors would flabbergast the author of this oath and render him speechless when confronted with the 1.2 million abortions done each year in this country alone, 97 percent of which are done for social or financial convenience.

Jonathan D. Adams, MD
State College

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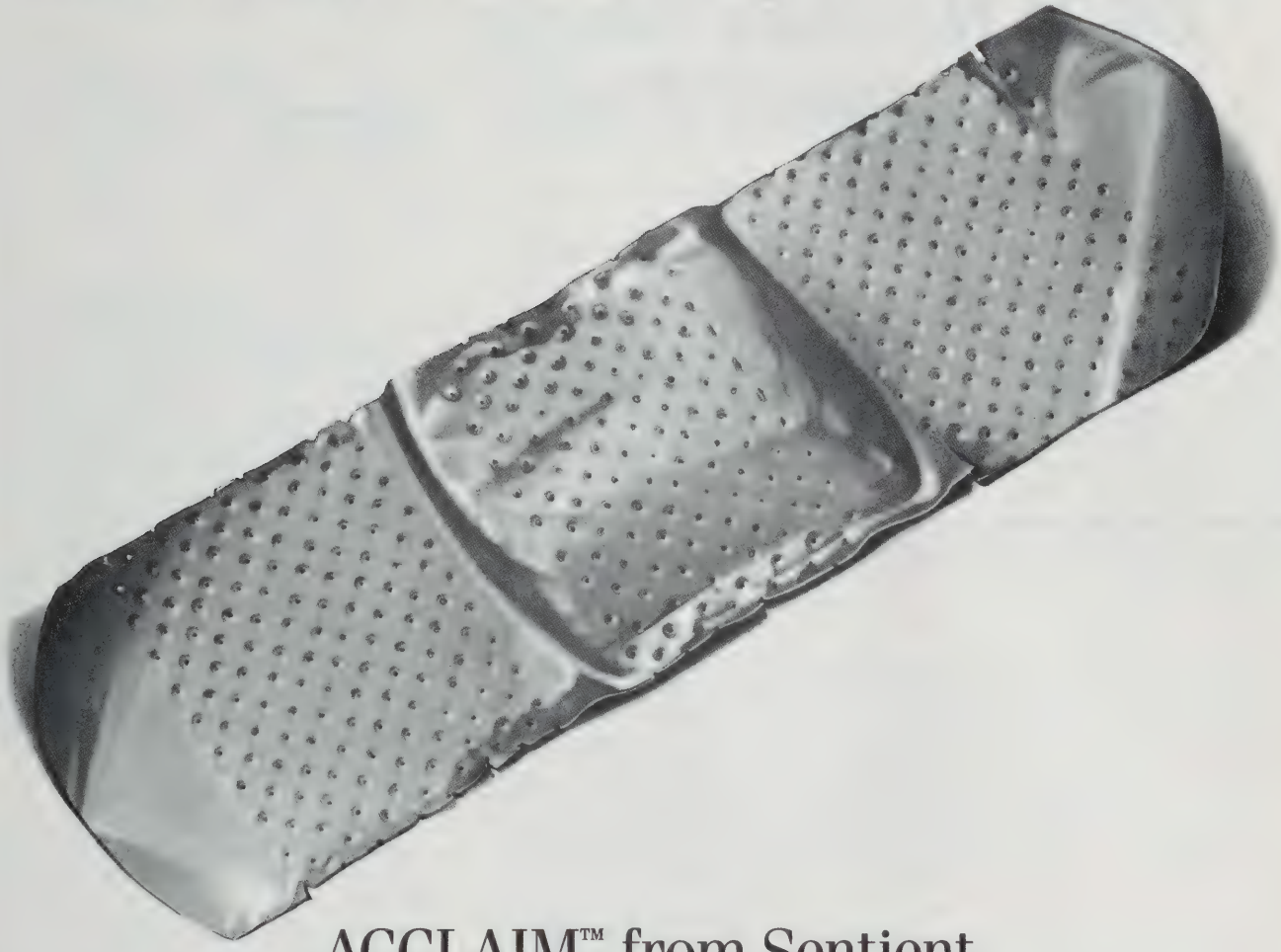
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DER Revises Waste Management Rules

Jeff Greenawalt

The Pennsylvania Medical Society urges physicians to review the complete infectious waste regulations for more detailed information. For a complete copy of the regulations, call the Council on Education and Science at 1-800-228-7823.

A number of improvements were made in new regulations designed to help physicians manage their infectious and chemotherapeutic wastes more easily. This article summarizes those improvements.

The Pennsylvania Department of Environmental Resources (DER) on April 9, 1988, published regulations on the disposal of infectious and chemotherapeutic wastes. These regulations created a considerable burden for physicians and led to an increase in expenses.

At the time, the Pennsylvania Medical Society expressed numerous concerns in meetings with representatives of the department suggesting some provisions were excessively restrictive, did not protect the public health, and only served to increase the cost of medical care. In response, on April 21, 1992, the department's Environmental Quality Board approved new regulations to supersede the old. They were published in the *Pennsylvania Bulletin* in August and are now in effect.

Definition of infectious waste

The 1988 version of the infectious waste regulations did not give sufficient specific information to eliminate many classes of waste which were not truly infectious. The regulations mentioned body fluids without further definition, leading to the conclusion that any item which contacted a patient constituted infectious waste. The new regulations are considerably more specific (see "General Classes of Infectious Wastes" on page 14).

Two major changes in the definition of infectious wastes will greatly affect physicians. First, sharps are now defined as *used* sharps. Thus, any sharps which are clean and were never used on a patient could be rendered unusable and disposed of as part of the regular trash stream. Second, included is the following new definition of body fluids considered to constitute infectious waste:

> *Liquids emanating or derived from humans and limited to the following: blood; cerebrospinal, synovial, pleural, peritoneal, and pericardial fluids; semen and vaginal secretions; and amniotic fluids. The term also includes the following fluids if they contain visible blood: feces, sputum, urine, and vomitus.*

Any materials used in physicians' offices that contacted patient body fluids not covered by the new definition can be disposed of through the regular trash stream.

On-site processing

The department has introduced the concept of "permit by rule" in the new regulations. What that means is small generators of infectious waste are considered to have a permit from DER for certain methods of handling infectious wastes which previously required a formal permit; and as long as the small generator complies with DER requirements, no additional permit will be required in most cases.

A small generator of infectious wastes is defined as one who generates less than 220 pounds of infectious waste per month. Under the permit-by-rule concept, physicians could autoclave, sterilize through chemical means, or incinerate the infectious waste on site. Note, however, incineration requires an air quality permit from DER.

When the waste is processed and no longer infectious, it becomes part of the normal trash stream unless it has not been rendered unrecognizable through incineration, grinding, shredding, etc. Physicians could still disinfect their recognizable waste, but additional paperwork (manifesting) is required, and the waste can only be placed in a landfill authorized by the department to receive such waste.

Mr. Greenawalt is the Society's director of educational and scientific affairs.

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In order to operate a disinfection facility, several conditions must be met. The facility must: 1) have any necessary permits under any applicable environmental protection acts; 2) be operating in accordance with those acts, conditions of permits, and orders of the department; and 3) keep daily records of the infectious waste processed, including weight or volume, and the location and method of residue disposal. Further, the processing must not have an adverse effect on public health, safety, welfare, or the environment; and the waste must be disinfected in accordance with the standards established within the regulations.

Disinfection of waste must occur before or during processing, and DER requires that a log be maintained for each disinfection unit used. The date, time, and operator for each use—as well as the dates and results of required calibration—must be recorded. Also, if steam disinfection is used, post-disinfection color reading of temperature-sensitive tape and the results of biological indicators for testing must also be recorded; for incineration facilities, the results of ash testing using a methodology approved by the department must be recorded. Note again that an incineration facility requires an air quality permit from DER.

Storage

For the purposes of storage, infectious waste must be separated into three classes—sharps, fluids, and other infectious wastes. Each must be stored in its own container, although the regulations do permit transporting them together to a processing facility. Liquid waste can also be disposed of through discharge into permitted sewage treatment systems that provide secondary treatment of the waste.

Under the new regulations, infectious waste can be stored for up to 30 days at room temperature, except for sharps containers which can be used until they are full. The regulations state, however, that should waste become putrescent, it must be disposed of within 24 hours. Physicians should also note that these limitations on the storage of infectious wastes do not apply to waste which has been disinfected.

Transportation

The regulations set standards for transportation of infectious waste to off-site processing facilities. Containers used for transport must be leak proof, rigid, moisture resistant, and strong enough to resist puncturing, tearing, or bursting. Waste must be transported by a method which prevents unauthorized access and the spread of any infectious agents, and which protects the material from animals, insects, etc. The waste must also be kept in a non-putrescent state and packaged in a way that prevents odors from escaping.

The surfaces of any cargo compartment used to transport the infectious waste must be impermeable and easily cleaned, and infectious material cannot be kept in an unrefrigerated vehicle for more than 48 hours. The regulations also establish

General Classes of Infectious Wastes

The Pennsylvania Department of Environmental Resources, in its new regulations on the disposal of infectious and chemotherapeutic wastes, defines general infectious waste as *"any municipal or residual waste which is generated in the diagnosis, treatment, immunization, or autopsy of human beings or animals, in research pertaining thereto, in the preparation of human or animal remains for internment or cremation, or in the production or testing of biologicals...."* General wastes fall into one or more of the following categories:

- **Cultures and stocks** of infectious agents and associated biologicals, including cultures from medical and pathological laboratories; cultures and stocks of infectious agents from research and industrial laboratories; wastes from the production of biologicals; discarded live and attenuated vaccines except for residue in emptied containers; and culture dishes, assemblies, and devices used to conduct diagnostic tests or to transfer, inoculate, and mix cultures.
- **Human pathological wastes**, including tissue, organs, and body parts and fluids removed during surgery, autopsy, other medical procedures, or laboratory procedures. The term does not include hair, nails, or extracted teeth.
- **Human blood and body fluid waste**, including liquid waste; human blood; blood products; items saturated or dripping with human blood; items that were saturated or dripping with human blood that are now caked with dried human blood, including serum, plasma, and other blood components which were used or intended for use in patient care, specimen testing, or the development of pharmaceuticals; intravenous bags used for blood transfusions; items that have been in contact with the blood of patients undergoing hemodialysis at hospitals or independent treatment centers; items contaminated by body fluids from persons during surgery, autopsy, other medical procedures, or laboratory procedures; and specimens of blood products or body fluids and their containers.
- **Animal wastes**, including contaminated animal carcasses, body parts, blood, blood products, secretions, excretions, and bedding of animals that were known to have been exposed to zoonotic infectious agents or non-zoonotic human pathogens during research (including research in veterinarian schools and hospitals), production of biologicals, or testing of pharmaceuticals.
- **Isolated biological wastes** and waste contaminated with blood, excretion, exudates, or secretions from humans who are isolated to protect others from highly virulent (CDC Class 4) diseases, or isolated animals known or suspected to be infected with highly virulent diseases.
- **Used sharps** that have been in contact with infectious agents or that have been used in animal or human patient care or treatment at medical research or industrial laboratories. Includes hypodermic needles, syringes (with or without detached needle), Pasteur pipettes, scalpel blades, blood vials, needles with attached tubing, culture dishes, suture needles, slides, cover slips, and other broken or unbroken glass or plastic.

requirements for vehicles which transport waste, including equipment to be used in the case of a spill. However, these requirements are waived for small generators who transport their own waste, as long as the waste is handled as previously mentioned.

Manifesting

Manifesting is a system of record keeping required in some circumstances. Physicians who use commercial infectious waste removal companies will encounter the manifest system and be called upon to complete a form before the hauler removes the material.

Manifesting does not apply for small generators who transport their own waste, but they must keep a log or shipment record for the receiver. The log or shipment record must include the name, address, and telephone number of the generator of the waste, the quantity of waste, and the date it was transported and accepted. A copy of that shipment record must be given to the receiver.

The regulations also contain an exception for the mailing of used sharps by small generators. The exception is granted if the sharps are sent by certified mail in compliance with postal regulations. Physicians must maintain a log with information on the weight of the package of sharps, the date it was sent, and the name and address of the person to whom it was shipped.

Manifesting is not required, but a form of shipping paper is if a small generator processes material on site but leaves it recognizable. In such instances, the physician must maintain a log which includes the name, address, and telephone number of the generator of the waste; the quantity of the waste; the name, address, and telephone number of the person who transports the waste; and the date it was transported and accepted. Such records must be kept for five years.

For those who encounter a manifest, it will most often consist of four parts: the first part is kept by the generator of the waste, the second by the person who transports the waste, the third by the owner of the facility which processes the waste, and that person must mail the signed fourth copy back to the original generator of the waste. Additional copies of the manifest are necessary if multiple transporters are used.

An important requirement for physicians is: if infectious material is shipped to a disposal facility and the generator of the waste does not receive the fourth copy of the manifest signed by the receiver within 15 days of the time the material was transported, the physician must contact the transporter, the receiver, or both to see where the material is. The generator is then required to notify the regional DER office within 24 hours of the status of that material. Disposal facilitates are required to send a copy of the manifest to the generator within seven days.

If the generator still has not received the manifest copy within 35 days, the generator must notify the regional office of DER by telephone and send an exception report to the central office of the department. The exception report should include a legible copy of the original manifest and a cover letter signed by the generator saying what was done in an attempt to locate the material.

Though the manifesting requirements may create additional paperwork for physicians, on the whole the regulations now in effect are an improvement over the old regulations and will probably reduce the cost of compliance.

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Restrictive Covenants in Physician Employment Agreements

Robert A. Auclair, Esq.
Diane Dallabrida, Esq.

Virtually all physician employment relationships are governed by employment agreements in which the physician and employer exchange promises. When embodied in contracts, promises are also known as "covenants." Certain covenants are restrictive in nature, including, most notably, covenants which prohibit competition ("non-competes"). Legal considerations regarding non-competes in particular center around the law of restrictive covenants in general. This article identifies legal issues which exist with respect to restrictive covenants under Pennsylvania law and offers certain caveats with respect to the negotiation of the non-competition components of the physician employment agreements.

Short of compensation and termination, promises which prohibit competition (non-competes) may be the most important provisions in physician employment agreements. Not surprisingly, they are generally among the most controversial items discussed or negotiated by the parties. The controversial aspect of the non-compete is understandable in that non-competition clauses and other restrictive covenants, such as non-disclosure of proprietary information and non-disturbance of employee, referral source, and/or contractual relationships, survive the termination of the employment relationship.

To further complicate the matter for all concerned, the courts have, in most jurisdictions including Pennsylvania, viewed restrictive covenant issues arising from physician employment agreements somewhat differently than restrictive covenant issues arising from other employment agreements. The root of the distinction is the goal of eliminating perceived or actual harm to the public which may be caused by placing restrictions upon the activities of physicians.

Restrictive covenants are, quite simply, a preferred means by which an employer may legally protect against the future loss of employees, clients, and/or customers. Certain courts outside Pennsylvania have gone so far as to recommend the use of such provisions as a preferred means of protecting client goodwill (which is incapable of protection as a trade secret) against potential interference by former employees.[1]

In health care employment contracts, it is generally referral sources and access to patients for which protection is sought. If the employee is a physician, the restrictive covenant will likely prohibit the practice of medicine in a specified area for a specified amount of time following the termination of employment.[2] The physician may also be prohibited from developing any relationships with entities or individuals with whom the employer contracts or to whom clinical or clinical administrative services are provided. In the case of a former employee who seeks to strike down such a covenant, the general rule of contracts which applies states that a "party who seeks to strike down his own written obligation must present evidence that is clear, precise, and indubitable."[3]

Simply stated, restrictive covenants should not be viewed lightly by the promisor/physician, nor should potential physician employees-to-be, when negotiating an agreement, blindly rely on lay opinions which declare that the actual covenants are "probably unenforceable."

Elements of restrictive covenants

The Pennsylvania Superior Court has determined that there are five primary issues that must be considered when the validity of a restrictive covenant is evaluated:

> *It is well settled in Pennsylvania that a restrictive employment covenant is valid if it is reasonably limited in duration of time and geographic extent, reasonably necessary to protect the employer, without imposing an undue hardship on the employee, ancillary to an employment relationship and supported by consideration. See e.g.,* Bettinger v. Carl Berke Assoc., Inc., *455 Pa. 100, 103, 314 A.2d 296, 298 (1974);* Jacobson & Co. v. International Environment Corp., *427 Pa. 439, 442, 235 A.2d 612, 619-20 (1967).*[4]

First, the general rule for the duration of a covenant is that it should be "no longer than necessary for the employer to put a new man on the job and for the employee to have a reasonable opportunity to demonstrate his effectiveness to the customers."[5] However, Pennsylvania

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courts have differed greatly with respect to how long a time limitation will be allowed to stand. The allowable amount of time has ranged from a few months to up to five years.[6]

The duration of five years, in fact, was upheld in favor of a physician's employer by a Pennsylvania trial court.[7] The Pennsylvania Supreme Court in *Boldt,* stated that a five-year period was not unreasonable as a matter of law. Note, however, that such a period is unlikely to be viewed as "reasonable," barring compelling circumstances; durations of two years or less are usually determined by Pennsylvania courts to be reasonable without additional inquiry.

Second, the area protected by the noncompete must be reasonably necessary to protect the employer's interest, and must be restricted to areas in which the employee had client contact.[8] With respect to physician employees, courts in other jurisdictions have held that the geographic area of the restriction will be generally upheld as reasonable if it is limited to the area from which the employer largely draws patients.[9]

Some employers choose to restrict the physician-employees from affiliating with specific hospitals, programs, or competing practices rather than to impose blanket restrictions over a geographic area. In covenants in which the geographic area is subject to interpretation, the courts will attempt to formulate a reasonable interpretation in view of the attendant circumstances.[10] Both the Third Circuit Court of Appeals and the Pennsylvania Supreme Court have enforced covenants which were silent as to geographic limitations.[11]

Also, it has been stated that restrictive employment covenants are presumed reasonable, absent a showing that the covenant works an undue hardship upon the employee.[12] A determination of the reasonableness of the employer's protection and the consequential harm to the employee requires a "sliding scale" type of analysis. That is, the harm to the employer, seeking to protect its goodwill and other interests, is weighed against the harm caused to the employee by enforcement of the contractual obligation.[13]

Generally and absent mitigating circumstances, the terms which restrict the employee must be noticeably harsh before the courts will entertain stamping judicial approval upon an open violation of the covenant by an employee. Because the courts favor freedom to contract, they tend to favor the interest of the employer, once again barring unusual or mitigating circumstances. Employees are generally held to their contractual obligations provided they agreed to them knowingly and their agreement was reasonable under the circumstances.[14]

The courts will not, however, support the imposition of restrictions which are broader than reasonably necessary for the protection of the employer.[15] For example, a psychiatric practice could not reasonably prohibit a former employee from practicing family medicine, regardless of whether or not the family practice was located within the restricted geographic area. Likewise, a practice which exclusively provides in-hospital services could not reasonably preclude a former employee from providing outpatient services in his or her home or office or, for example, teaching at a medical school.

Finally, the act of accepting employment even if that employment is terminable at will, receiving broader responsibility and/or a promotion, or any other such change in status is sufficient to satisfy the requirement that the restriction be "ancillary to employment" and supported by consideration.[16] The imposition of restrictive covenants by an employer following the commencement of employment must be accompanied by the imposition of a corresponding benefit to the employee, either in the form of enhanced compensation, benefits, job status, or the like.[17]

Medical practitioners

As discussed earlier, compared to restrictions placed upon employees within traditional business arrangements, restrictions involving physicians and their activities have been carefully scrutinized by the courts in response to a concern that such restrictions run contrary to public health interest. With respect to such restrictions, the battle lines are clearly drawn.

On one side are physician-employees who frequently agree to the restrictions solely because they are woefully lacking in bargaining power at the time employment is originally negotiated. Employers, on the other side, feel entitled to restrict physician-employees because they invest time, effort, and money into the physician-employee's training and assimilation into the practice. The employers also feel compelled to limit competition from former employees in order to protect goodwill and other assets. Squarely in the middle of the battle lines lies the public's interest in unrestricted access to medical care.

The needs of the public have been advanced, to some extent, by the courts in Pennsylvania, which routinely inquire into whether or not a sufficiency or shortage of physicians exists in the area covered by the non-compete.[18] The sufficiency/shortage inquiry is performed by the courts because a shortage of physicians in a certain area may inflict harm upon society in general "by depriving the community involved of a desperately needed service."[19]

In *New Castle Orthopedic Associates v. Burns,* the court determined there was indeed such a shortage. In that case, the physician-employee presented four local physicians as witnesses who testified that they faced delays of up to four months when attempting to arrange appointments for their patients with orthopedic surgeons. Alternatively, the New Castle opinion cited numerous cases from other jurisdictions in which covenants were enforced against physician-employees who failed to present conclusive evidence of such a shortage.[20]

Without proof of shortage, physician employment covenants are subjected to the same inquiry of reasonableness as are all other restrictive covenants. Obviously, the outcomes of disputes involving the restriction of physicians' activities are difficult to predict. This is true not only in Pennsylvania, but in most other jurisdictions. The following cases are indicative of the unpredictable nature of physician/former employer disputes.

In *Canfield v. Spear,*[21] an Illinois Appellate Court found that a restrictive covenant in a physician's employment contract did not harm the public and that the terms of the agreement were reasonable. The agreement stated that the physician-employee could not, after termination, practice medicine within a 25-mile radius for a period of three years. The employee contended that, because his specialty was dermatology, not allowing him to practice in the area in question would considerably diminish the "dermatologist-patient ratio."[22] It was also asserted that the employer had failed to prove the damaging consequences of the former employee practicing within the 25-mile radius and that compelling the employee "to live up to his agreement would be a hardship."[23]

The court stated that the defendant had no patients when he came to the area, nor was he originally from the area. Further, at the time he signed the contract, he was more than competent to understand the provisions of the agreement. "He has accepted the benefits of the contract and must take the burdens as well," stated the court.[24] The Illinois court also contended that no public interest was violated. If a shortage of a particular type of doctor exists in a specific area, other doctors will move to practice there.[25]

The Idaho Appellate Court, by contrast, in *Dick v. Geist,*[26] took a different stance. The two physician-employees in *Dick v. Geist* had an agreement similar to the one in *Canfield v. Spear.* They were forbidden from practicing within a 25-mile radius for two years after termination. Both employees were pediatricians, and without their services there would have been only five pediatricians practicing in the restricted area. Although other pediatricians were available to take over the workload of the former employees, there was an apparent lack of interest in treating critically ill newborns displayed by at least one of the new (replacement) employee physicians.

> *Such an interest is important because providing care for even one critically ill newborn per month adds a tremendous burden to a doctor, in terms of time spent at the hospital and away from his office practice...the treatment of critically ill newborns involves an "intensive, exhausting type of care that requires long hours."*[27]

The court weighed the community's interest with the interest of the employers of physicians and found that the public interest would have been significantly harmed if the former employees were forced to abide by the restrictive covenant.[28]

Enforcement

An employer, once aware that a former employee is in violation of a non-competition provision, must act quickly so as not to suffer losses unnecessarily or otherwise give the appearance that the violation is not serious or damaging.[29] The relief generally sought by an employer is equitable and includes temporary restraining order(s) and permanent injunction(s) which serve to prohibit the restricted activities for the duration of the covenant. Pennsylvania courts have also granted partial relief, such that the enforcement of an overly broad covenant may be limited in scope to the extent reasonably necessary to protect the employer.[30]

Beyond equitable relief, actual damages incurred can be quite difficult to quantify. Possibilities and complications involved in establishing the dollar value of damages caused to an employer by virtue

of the breach of a non-competition provision are almost limitless and thus outside of the scope of this article. Suffice to say, however, that the risk of establishing or not establishing dollar damages, can be of great consequence to an unsuccessful party. Likewise, liquidated damages—those which are agreed to in the body of the employment agreement as appropriate compensation for a breach—should also not be viewed lightly.

Recommendations

The key to living (and working) with restrictive covenants following the termination of employment is to have properly negotiated the provisions in advance of entering into the agreement. The comment made earlier regarding disproportionate bargaining power is likely not lost on the bulk of physician employees, particularly those recently in residency programs. Irrespective of bargaining power, employees must carefully review all of the restrictive covenants prior to entering into an agreement, if only to evaluate the extent to which compliance after termination may create a hardship. For example, the employee must determine whether or not compliance with the provisions will require relocation after termination. If so, potential or likely future relocation should be factored into the evaluation of the employment relationship.

Also, the employee must look at the non-competition provision carefully to evaluate the occurrences which trigger its operation. For example, does the non-compete apply even if the physician employee is terminated without cause? A physician-employee should be reluctant to sign an agreement that may, without fault or reason, effectively require the employee to relocate upon the receipt of 60 or 90 days notice.

Employers, on the other hand, are advised to carefully and specifically determine the interests that require protection in advance of inserting restrictive language into the agreement. All aspects of the restrictive covenants should be directly related to the protection of a significant business interest. Though certain courts have ordered partial enforcement of restrictive provisions, there exists the possibility, if not probability, that an overly broad clause will be declared invalid and, as a consequence, unenforceable.

Employers are also advised to describe in the agreement, activities which are not prohibited by the restrictive covenants. For example, an agreement may state: "this agreement shall not be construed as precluding the employee from providing outpatient services and/or...," etc.

Finally, both employers and employees may benefit by the inclusion in the agreement of an arbitration or dispute resolution provision, if only to provide an alternative to costly state court litigation. However, employers are cautioned to retain the option of proceeding in state court to obtain restraining orders and other injunctive relief.

Evaluation reveals that although certain parameters have been established by case law, disputes regarding the enforceability of restrictive covenants are difficult to predict. Careful negotiation and contract drafting are the best tools available, to both employers and employees, to minimize the risks which are incidental to the divergent enforcement patterns which have emerged from restrictive covenant-related, post-employment litigation. Employers and physician-employees are advised to carefully scrutinize all restrictive covenants prior to executing the agreements in which the covenants are contained.

Reprint requests should be sent to Robert A. Auclair, Esq., Goldman, Marshall & Muszynski, P.C., 1515 Market Street, Suite 500, Philadelphia, PA 19102.

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ACTIONS OF THE BOARD OF TRUSTEES, SEPTEMBER 9, 1992

SOCIETY TAKES ON DRUG PRESCRIBER EDUCATION

The State Society's Board of Trustees at its September 9 meeting approved the recommendation of the Drug Utilization Review Policy Committee to sign a contract with the Pennsylvania Department of Public Welfare (DPW) for the marketing and educational intervention aspects of DPW's Medicaid Retrospective Drug Utilization Review (RDUR) program.

Under mandate of the Omnibus Budget Reconciliation Act of 1990, DPW is developing the statewide RDUR program to educate prescribers about drug utilization issues and change prescribing patterns to improve the quality of medical care and lower health care costs. The program's primary audience is physicians treating Medical Assistance (MA) patients, but general education will target all Pennsylvania physicians.

While involving intervention strategies, the program is not punitive in any way. Under the contract, the Society will design, develop, and implement the program. Specific intervention strategies and educational materials, including a strong public relations and promotional component, will be developed using market research findings. Activities might include:

- presentations about the RDUR program and drug/prescribing topics at county medical society meetings;
- journal articles on topics relevant to program goals;
- presentations at medical schools;
- presentations at hospitals with high MA populations;
- paid advertising in appropriate medical publications, newspapers, radio, or television;
- educational seminars offering CME credits; and
- press releases.

The program, the first of its kind in the nation, will begin with a nine-month contract with DPW; yearly extensions are planned thereafter.

HIV PROCEDURES OPPOSED BY SOCIETY

At the recommendation of the Council on Education and Science, the Society will use all means available to prevent the implementation of the Pennsylvania Department of Health's "Procedures for Facilities Following Discovery of HIV-Infected Health Care Workers." The Society opposes the procedures on both scientific and legal grounds; litigation is being considered.

Presented by the department and the Hospital Association of Pennsylvania (HAP) at meetings of a joint Society-HAP Task Force formed to address this problem, the procedures outline steps to follow if a physician or health care worker is diagnosed HIV positive. Included are procedures to review the physician's practice and health.

Society leaders agree: 1) the procedures are inconsistent with Society policy, are vague, and violate Pennsylvania laws; and 2) the review is unnecessary. Society representatives were scheduled to meet with Secretary of Health Allan S. Noonan, MD, MPH, to discuss the Society's position.

At press time, HAP leaders had approved releasing the procedures, along with explanatory materials and supporting documentation, to its members.

ELECTRONIC BILLING AFFILIATE SELECTED

The Pennsylvania Medical Society will affiliate with Physicians Practice Management (PPM) to offer an electronic billing service to physicians.

The new service will: 1) provide leadership, information, and guidance on electronic claims submission; 2) minimize the risk for physicians who wish to develop the capability to submit claims electronically; 3) recommend proven vendors; 4) provide cost-effective recommendations to the membership; and 5) generate revenue for the Society.

PPM, a privately owned electronic billing company based in Indiana, has 126 medical practice sites in Pennsylvania enrolled in its Claim Net Clearinghouse.

For specifics about the program, call the Society's Department of Physician Services at 1-800-228-7823.

CHANGES SOUGHT IN LAW ON MANAGED CARE REVIEWS

The Society plans to seek legislation to require managed care payors to allow participating providers the right to appeal adverse utilization review decisions regarding care provided or initiated.

Draft legislation approved by the board would mandate such an appeal option and allow managed care participating providers to challenge utilization review determinations in a judicial action.

Because the opportunity to appeal is meaningless without appropriate notice of the factual basis and rationale of the determination, the legislation would also require timely and complete notice of both the initial and reconsideration determinations.

KEPRO OVERSIGHT RECOMMENDATIONS APPROVED

The board approved several recommendations of the Ad Hoc Committee on KePRO Oversight. These direct:

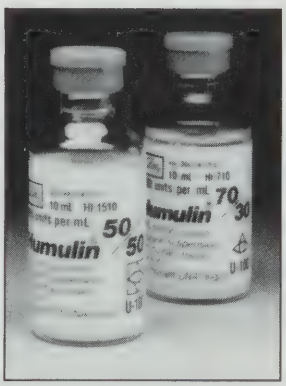
- the Society's Hospital Medical Staff Section (HMSS) to encourage hospitals to assist physicians in transferring their office histories and physicals to hospital medical records in an acceptable manner;
- the Interspecialty Section to review the Health Care Financing Administration's ambulatory surgery generic screens to determine whether the requirements are appropriate;
- the Society—in response to a growing concern by members regarding the quality of KePRO reviews—to provide a mechanism for obtaining specialty society comment on potential physician advisors for KePRO; and
- the HMSS to investigate the advisability of advocating that hospitals that have appropriate emergency room procedures in place share them with those that do not, in order to curtail citations to physicians for not performing appropriate tests on patients admitted to the emergency room.



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John W. Lehman, MD, Beaver Falls, served as the Society's 1991-92 Tenth District trustee.

SUPPORT WITHDRAWN FOR CRNP PRESCRIBING RIGHTS

At the recommendation of the Interspecialty Section, the board withdrew its support of the extension of prescription writing to nurse practitioners.

While there is no doubt that the certified registered nurse practitioner (CRNP) plays a positive and important role in caregiving, the section believes limitations on CRNP practice must be imposed since CRNPs are not physicians.

The board originally approved a conditional recommendation accepting nurse practitioner prescribing as long as it is controlled by the physician. However, after further consideration, the board decided it would at this time be inappropriate to support such a proposal.

TOXIC RELEASE INVENTORY POLICY ADOPTED

In response to an Environmental Protection Agency (EPA) request for Society support and involvement in a new Toxic Release Inventory (TRI) project, the Society's Board has adopted as policy a proposed plan recommended by the Commission on Environmental and Occupational Health.

While not specifically endorsing TRI, the commission agrees that the project may provide useful information on toxic releases for physicians, citizens, and corporations. The commission supports informing Society members of the availability of TRI. A summary of the commission's proposed plan is slated for publication in a future issue of PENNSYLVANIA MEDICINE.

PUBLIC HEALTH PLAN TO BE IMPLEMENTED

The Society will implement a public health plan, proposed by the Council on Education and Science, to guide its efforts in the public health arena.

The plan identifies priorities—education and community based programs, maternal and infant health, tobacco usage, alcohol and drug abuse, violent and abusive behavior, unintentional injuries, HIV, and environmental health—and outlines general actions which the Society could undertake.

The plan was created in response to recommendations by Society Past President Robert N. Moyers, MD, in a speech to the 1991 House of Delegates.

TRUSTEES AUTHORIZE MEETINGS, STUDY

The Board of Trustees authorized the development of regional meetings of Society leadership and members, and the study of regional board meetings, as recommended by the Committee on Organization and Operation of the Board.

In discussing ways the board could more effectively represent members, the committee pointed to the successes individual leaders and groups of leaders have had over the last year meeting with physicians throughout the state. According to the committee, formalizing that concept through regional meetings could improve communication between leadership and members.

As a second step in that process, the Society will also study the logistics, scheduling, and costs related to holding occasional board meetings in various regions of the state.

DR. AUSTRIAN RECEIVES AMA NOMINATION

Robert Austrian, MD, Philadelphia, has been nominated by the Society for the AMA Distinguished Service Award with a letter of endorsement from the board.

Dr. Austrian is director of the World Health Organization Collaborating Centre for Reference and Research on Pneumococci at the University of Pennsylvania. He is best known for developing the Pneumovax pneumonia vaccine.

ADDITIONAL ITEMS APPROVED BY BOARD

In response to several other committee recommendations approved by the board at its September meeting, the Society will:

- Make available to the membership and public another printing of the Society's living will brochure entitled, "Dignity in Death, Dignity in Dying." As previously offered, single copies are available to the public by sending a self-addressed, stamped envelope to the Society's Public Affairs Department; 100 free copies are available to each Society member; and multiple additional copies are also available.
- Educate members about managed care and how to cope with it; and assist members in establishing physician-owned and -controlled alternative delivery systems, physician networks, etc.
- Commission the Society's Trust to conduct a comprehensive study of the status of the types of insurance offered to Pennsylvania medical students and residents.
- Study the feasibility of reimbursement for patient management via telephone.
- Halt collections of past dues assessments from former Society members who rejoin. Past Society policy stated that any member terminating his/her membership to avoid assessment would be required to pay the outstanding assessment in order to rejoin.



Board members Howard A. Richter, MD (left), and John W. Lawrence, MD, 1991-92 vice chairman of the Board, participated in discussion at a recent meeting of the Society's trustees.

UPDATE: VIRAL INFLUENZA 1992-93

As influenza season sets in, the Department of Health again reminds Pennsylvanians and especially physicians of the need to consider influenza vaccination for high-risk persons. On the average, more than 10,000 persons per year in the U.S. die of this disease or its complications.

Vaccine recommendations

Because of the potentially serious effects of viral influenza, the Department of Health recommends that high-risk persons over the age of six months receive influenza vaccine every year, before the beginning of December. Vaccines are recommended for the following:

- Persons with chronic disorders of the heart, lung, kidneys or immune system, hemoglobinopathies, or diabetes mellitus.
- Anyone who is 65 years of age or older.
- Children from ages six months to 18 years receiving long-term aspirin therapy (because of the risk of Reye's Syndrome).
- Any person who has extensive contact with high-risk persons (i.e., health care providers or persons living in the same house or institution as a high-risk person).

The predicted influenza strains for this season are: A Beijing/353/89-like (H3N2), A/Texas/36/99-like (H1N1), and B/Panama/45/90-like. The current vaccine contains antigen against each of these strains.

Children from six to 35 months of age should receive one or two doses of 0.25 ml. of split virus. Children from three to eight years of age should receive one or two doses of 0.50 ml. of split virus. Children from nine to 12 years of age should receive one dose of 0.50 ml. of split virus. Persons over this age should receive one dose of 0.50 ml. of whole or split virus.

Anyone with a known history of anaphylactic reaction to eggs or influenza vaccine and anyone with febrile illnesses should check with his or her physician about the advisability of receiving the vaccine.

Amantadine recommendations

The anti-viral medication Amantadine is effective against influenza A, either used as prophylaxis or as treatment if given within 48 hours of illness onset. It is recommended as prophylaxis in high-risk persons under the following conditions:

- When exposure is likely in an unimmunized person, because the virus is known to be present in the community, and sufficient time for immunization to be effective does not exist—it generally takes two weeks following vaccine completion for full immunity to be achieved.
- When a poor antibody response is expected due to an immune deficiency condition such as HIV infection.
- When a vaccine is medically contraindicated because of anaphylactic hypersensitivity to egg protein or another vaccine component.

Dale Tavris, MD, MPH
Pennsylvania Department of Health

PITT TESTS NEW HIV/AIDS DRUG

Researchers from the Pitt Treatment Evaluation Unit (PTEU) at the University of Pittsburgh Medical Center are participating in a new multicenter study on an antiviral drug for the treatment of HIV infection and AIDS.

Preliminary clinical studies indicate that the drug, Stavuding or D4T, produced by Bristol-Myers Squibb, may increase the number of immune cells in the blood for a longer time than the FDA-approved drugs, Zidovudine (AZT) and dideoxyinosine (DDI).

According to PTEU researcher John Mellors, MD, assistant professor of medicine, the study is designed to compare the safety and efficacy of D4T versus AZT in HIV-infected patients. Preliminary clinical studies indicate D4T is well-tolerated at the prescribed dosage intended for this study.

BUREAU LOOKING FOR AIDS-LIKE ILLNESSES

The Division of Epidemiology, Bureau of HIV/AIDS, Pennsylvania Department of Health, is culling its records as part of a Centers for Disease Control (CDC) national surveillance system set up to look for more cases of AIDS-like illnesses.

The CDC is also asking health care providers to report, through the Division of Epidemiology at (717) 783-0481, patients who have:

- CD4-positive T-lymphocyte depletion (absolute CD4-positive T-cell level less than 300 cell/uL or less than 20 percent on more than one determination),
- no serologic evidence of HIV infection, and
- no defined immunodeficiency or therapy associated with T-cell depletion.

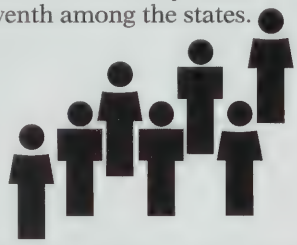
Although no cases have been reported in children, HIV-negative pediatric cases with unexplained depletion of CD4 cells, as defined by age-adjusted normal CD4 counts, should also be reported.

For additional information on unexplained CD4-positive T-lymphocyte depletion, see the July 31, 1992, *Morbidity and Mortality Weekly Report.*

Excerpted from "HIV/AIDS Update" (Vol. 5, No. 7)
Pennsylvania Department of Health

Pennsylvania AIDS Status

Pennsylvania recorded 6,668 AIDS cases between January 1, 1991, and September 2, 1992. According to the state Department of Health, Pennsylvania ranks seventh among the states.



ALZHEIMER'S TOLL-FREE INFORMATION LINE OFFERED

The Alzheimer's Disease Education and Referral Center of the National Institute on Aging (NIA) is offering a toll-free number for Alzheimer's information.

Health professionals and the public may call 1-800-438-4380 to ask questions about Alzheimer's disease, identify resources and materials, receive a calendar of upcoming conferences, learn about NIA-sponsored clinical trials, and order free publications, including "1992 Progress Report on Alzheimer's Disease" and "Alzheimer's Disease Q&A."

Information specialists at the Disease Education and Referral Center are available weekdays between 8:30 a.m. and 5:00 p.m.

HOUSE PASSES TWO SPECIAL SESSION BILLS

The House of Representatives passed bills on workers' compensation reform and health care for uninsured children during a special session convened by Governor Robert P. Casey beginning October 5. Both bills were sent to the Senate for committee consideration.

Workers' compensation reform

House Bill 2, sponsored by Representative William Lloyd (D-Somerset), sets the fee schedule for workers' compensation at 117 percent of current Medicare allowance. Future updates, if any, would be dependent on changes in Medicare.

The bill excludes insurance companies from setting up coordinated care organizations (CCOs) and limits the aggregate reimbursement to CCOs for health care services to the 117 percent cap. It also includes changes in peer review, handling of medical records, and insurance reform.

Earlier the House defeated 93-106 an amendment which would have inserted the "Madigan-Mellow" language, including 120 percent of Medicare with an annual update. Meanwhile, the governor continues to meet with Senators Roger A. Madigan (R-Bradford) and Robert J. Mellow (D-Lackawanna) to iron out their differences.

The Senate was expected to return to Harrisburg on November 9, at which time House Bill 2 would move there for review. At press time, the Society was uncertain what the outcome of the issue would be, but it continued to adamantly oppose the permanent tie to Medicare.

Health care for uninsured children

House Bill 1, similar to House Bill 20 on indigent care and sponsored by Representative Allen Kukovich (D-Westmoreland), is a comprehensive plan for health care for uninsured children, from infancy to age 19. The House approved an amendment limiting the cost of the child health program to the two-cent cigarette tax revenue set aside for such a purpose, thus preventing the use of state General Fund monies.

Onerous language, included in early versions of House Bill 20, tying participation to medical staff privileges and licensure, was *not* included in House Bill 1. However, the bill requires joint action between hospitals and medical staffs to assure access to Medical Assistance recipients. Participation in county or state medical society referral systems meets this requirement. The state Insurance Department would have oversight responsibilities, with Blue Cross and Blue Shield providing administrative services under contract with the department.

House Bill 20, including a Society referral amendment similar to that in House Bill 1, remains in the Senate Appropriations Committee. A Conference Committee is likely to resolve differences between the House and Senate versions of the bill if new language proposed by Democratic legislators is not acceptable.

POLITICAL CAMPAIGN SEMINAR HELD

Fifty-one physicians and auxilians participated on September 30 in a day-long political campaign seminar in Allentown. The seminar was designed to introduce attendees to the world of political campaigns and enhance their desire to participate in a campaign of the candidate of their choice.

Toolbooks on fundraising, campaign tactics, and political leadership were used. The seminar also included a hands-on, fundraising exercise. R. William Alexander, MD, a member of the AMPAC board, spoke to the group during their luncheon. The seminar was jointly sponsored by the Lehigh County Medical Society, PAMPAC on behalf of the Pennsylvania Medical Society, and the Political Education Department of the AMA.



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The value of membership in:



Pennsylvania Medical Society

Doctors physicians — working for you



American Medical Association



Your County Medical Societies

PUBLISHED FALL 1992

Here are just a few examples of what we've done in 1991/92. . . .

HOW YOU PRACTICE:

We helped you get a practice **started**, be more **efficient**, cope with **bureaucracy** and get all the **reimbursement** to which you are entitled. We pushed for **less hassle**.

Medicare Fee Schedule and **RBRVS** demanded tremendous attention. We were one of the first organizations to send a concise explanation of the new evaluation and coding system — exclusively for our members. More than 2,500 physicians and staff went to seminars we held across the state. We distributed 7,000 free pocket-sized reference booklets on new E/M codes — one of four publications created especially for members.

Medicare **payments nearly doubled** for code 99274. We got involved and Blue Shield, the carrier, admitted errors in calculating this under RBRVS. Payments were as low as $52.47 and went to as high as $100.39. The carrier also set up a separate P.O. box because your Society carried forward your complaints about "lost" documentation.

Members got **a dozen free publications** on topics like Blue Shield audit and review procedures, marketing, practice management, office automation software, practice options, retirement, quality management and the National Practitioner Data Bank. The Society's 45-chapter **reference** book "Laws and Regulations Affecting Medical Practice" became available to you at $55, half off the regular $110 price.

Numerous **Blue Shield issues** included profile updates, pathology codes, Special Care and Blue Choice contracting. We helped get less onerous provisions for physicians in Blue Choice.

The Society and AMA worked to provide members with an **OSHA** compliance kit, including a model control plan, for only $10 — comparable kits sold for $100 or more. 700 attended our seminars on OSHA compliance.

Members got **discounts on seminars**, like a $100 discount on the seminar "How to Get the Most Value for Your Practice."

We helped you comply with the Clinical Laboratory Improvement Act, the new Americans with Disabilities Act and safe harbor **regulations**, and we argued your case before **state regulators**.

In a state/AMA joint venture, a new **group practice** program was implemented to improve representation of and services to this rapidly growing sector.

Unique benefits included group insurance, referrals, a gold MasterCard with a $50,000 limit and placement services as well as liability coverage through the Pennsylvania Medical Society Liability Insurance Company (PMSLIC).

An **electronic billing service** was developed and slated to be available in November 1992.

"This is a truly democratic organization where all members have a voice."

Donald G. Ferguson, MD,
Pennsylvania Medical Society
president 1992-93

Work began on a guide book on **CCOs** and a paper on the ABCs of **managed care** to be available in 1993.

A Medicaid "**ombudsman**" program got up and running in 11 counties. A state-wide service to cut red tape was slated to begin in winter 1992.

IN EDUCATION:

Education is a basic function of organized medicine.

The Society's Educational and Scientific Trust provided more than $1/2 million in **student loans** and continued active counseling for troubled physicians.

In one of the best **CME** accreditation programs in the nation, the Society had 65 CME providers. The Society sponsored 11 Category 1 programs and jointly sponsored 13 more.

The state Society, county societies and AMA answered thousands of calls from physicians and their staffs. Members have access to these numbers for invaluable **information and service**:

1-800-228-7823
(Pennsylvania Medical Society)

1-800-262-3211
(American Medical Association)

ON CAPITOL HILL:

If we think legislation and regulation are bad now, what would happen without organized medicine?

The state Society complements AMA's aggressive presence in the nation's capitol the way our county societies complement our actions in dealing with the Pennsylvania General Assembly. Efforts include personal visits to elected representatives and appointed officials in Washington, D.C. and Harrisburg to carry your messages **"to the hill."**

Society and AMA efforts restored a significant proportion of the cuts in overall **Medicare** fees when a 16% reduction was threatened!

The Society began fielding physician "quick response" and "legislative action" or LAT teams to help deal with the ever-escalating attempts to regulate medicine. We looked at about **6,000 bills** in the state legislative session to identify those which might affect you.

In 1992, tremendous energy went into molding **workers' compensation** reform. Why? It has implications for you whether or not you treat workers' comp cases. Society efforts focused on arguing the hazards of a Medicare link. Hundreds of members wrote, called and even marched on the state Capitol. Countless hours went into negotiating and analyzing various plans.

State **living will** legislation, a high priority, was signed into law. We immediately responded with a new living will brochure — by September, 50,000 copies had gone to patients and physicians.

There are better ways to help patient access than by tying **Medicaid** participation to your hospital privileges or licensing. Your Society offered alternatives and got these punitive provisions deleted from House Bill 20.

We helped win higher Medicaid fees — that meant **$25 million** more reimbursed to physicians in the first half of 1992. The Society also worked to stretch the available Medicaid dollars further in the state's 1992-93 budget.

We drafted legislation on third- and fourth-party **review** and to reform the **liability system**.

The Society and the AMA fought attempts by **third-party payers** to limit reimbursements to hospital-based physicians via on all-inclusive rate.

Dozens of other state legislative issues included childhood immunizations, uniform claims, mammography, and keeping a physician at the helm of the Health Department, as the Society worked to help draft, amend, stop or move bills.

NEWS AND INFORMATION:

Members get up-to-date information such as two, free, monthly state publications (the Executive Report newsletter and the journal, Pennsylvania Medicine.) JAMA, American Medical News, county communications and other important professional news.

"Medicine has given me much. One way I repay medicine is participating in an organization which strives to maintain the high standards of medical education, practice and ethics. Just as medicine needs you, you need organized medicine."

Betty L.Cottle, MD, chairman, PMSLIC

IN THE COURTS:

We initiated a challenge to Medicaid's failure to pay co-payments for patients who also qualify for Medicare — a case which could mean **$40 million** to Pennsylvania physicians.

We filed amicus (friend of the court) briefs in several cases, such as those on **malpractice** and **peer review**, which could have long term effects on you and your practice or patients.

FOR YOUR PATIENTS & YOU:

Organized medicine continues working to bring informed and rational discussion to the **health care reform** debate. Your Society and the AMA are constant reminders that cost and access must be balanced with **quality care**.

In late 1992, the first **physician-specific data** was set to be released by the Pennsylvania Health Care Cost Containment Council (PHC4). While still less than perfect, the report is vastly improved because of Society efforts. Morbidity statistics, for example, were deleted at our urging.

Efforts continued to bring attention to **underserved areas** and how **hassles** contribute to higher costs. The Society pursued safeguards to protect patients and physicians in **peer review** and **managed care**.

DUR, **drug utilization review**, is the latest "buzzword" in cost containment. Pennsylvania's Medicaid DUR is unique, a first in the nation because of Society input. We've contracted to provide services which will lean heavily toward physician education. Your Society continued to dog the Department of Aging in 1992 to change its DUR procedures in the Lottery-funded PACE program.

We were active in helping set physical and mental criteria for **drivers' licensing** and led a forum on hazardous **waste incineration**.

A new **public health** plan was adopted to increase the Society's involvement and visibility. We were involved in public health on a number of fronts, from mammography to substance abuse. One Society public affairs program honored pharmacies which refuse to sell tobacco. The AMA continued its public health efforts such as the anti-smoking — "Joe Camel" — campaign that received national attention.

We've handled about 500 **media contacts** in a year and got positive headlines on issues like HBV and living wills in our efforts to enhance physician image.

We initiated pilot **Medicaid referral** programs for our counties and got state approval for a managed care/Medical Assistance pilot.

IN YOUR COMMUNITY:

Your county society served as:

- an effective way to communicate with area legislators, business and health-related groups;
- a broad referral base;
- a place to resolve ethical issues;
- a center for public health and other community programs;
- a peer reviewer, and
- a liaison with local media.

WHAT IS THE VALUE OF MEMBERSHIP?

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Robert N. Moyers, MD,
Pennsylvania Medical Society
president 91-92

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Your County Medical Societies

"We must all hang together, or assuredly we shall all hang separately."

Benjamin Franklin

REIMBURSEMENT QUESTIONS ANSWERED

A number of general questions have been raised by physicians regarding Medicare payment reform and third-party reimbursement. The following is a sampling of those questions, answered by Pennsylvania Blue Shield Medicare and amended *in italics* by the Society.

Is it appropriate to bill a consultation for new patient encounters?

A consultation is a type of service provided by a physician whose opinion or advice is requested by another physician regarding evaluation/management (E/M) of a specific problem. The request and need for the consultation must be documented in the patient's medical record. The consultant's opinion must also be documented in writing to the requesting physician and in the patient's medical record. A consultation is appropriately billed only if all the above guidelines are met. *It is appropriate to bill a consultation for new patient encounters, as long as the service being rendered during the encounter meets the criteria established for consultations.*

Can a confirmatory consult be initiated by a patient or only by another physician?

Confirmatory consultations are services provided by physicians to individuals seeking an opinion of the necessity or appropriateness of a previously recommended medical or surgical treatment. For confirmatory consultations, the patient may initiate the service and another physician need not be involved.

Is cerumen impaction lavage part of an office visit?

Procedure code 69210 (removal of impacted cerumen, one or both ears) is classified as a minor surgical procedure. An office visit on the day of the procedure would not be reimbursed unless the patient's condition required a significant, separately identifiable E/M service above and beyond the usual pre- and post-operative care associated with the procedure. If a separately identifiable E/M service is provided, the -25 modifier must be reported with the E/M procedure code.

How should a medical examination for the purpose of "clearing" a patient for surgery be billed by a non-surgeon?

The Health Care Financing Administration (HCFA) has recently clarified that a request of a surgeon to a patient's primary care physician to perform a "clearance" for surgery is not considered a consultation since the primary care physician is responsible for the overall management of the patient. The primary care physician should bill an appropriate E/M procedure code (inpatient or office). If the primary care physician has not seen the patient within the past three years, a consultation code may be used. *This policy change has raised objections among Society membership. These objections are being made known to the AMA, HCFA, and the Medicare carrier.*

What is the correct policy for billing multiple surgical procedures performed at the same operative session on the same patient by the same physician?

- Report the major surgical procedure code without utilizing the multiple procedure code modifier 51.
- Report the additional surgical procedures utilizing the 51 procedure code modifier.

Payment for multiple surgical procedures will be based on the following:

- 100 percent of the fee schedule amount for the highest valued procedure.
- 50 percent of the fee schedule amount for the second highest valued procedure.
- 25 percent of the fee schedule amount for the third through fifth highest valued procedures. Claims reporting more than five procedures are subject to manual review. Medical documentation, such as operative reports, must accompany the claim when billing for more than five procedures.

Payment for dermatology procedures, as defined by HCFA, will be based on the following: 100 percent of the fee schedule amount for the highest valued procedure; 50 percent of the fee schedule amount for the second through fifth; and 10 percent payment for services beyond the fifth. No additional documentation is required.

What procedure code is to be used for repeat pap smear with history of previous abnormal smear?

Effective for services performed on or after January 1, 1992, physicians should use codes 88151 or P3001 as appropriate. When reporting P3001, physicians must list a primary and secondary diagnosis code when billing Medicare for screening pap smears—report diagnosis code V76.2 or V15.89 as the primary diagnosis and V72.6 as the secondary diagnosis code.

Will Medicare pay for the administration of an injection on the same day as an office visit?

Payment for the administration of a therapeutic injection will *not* be made when the injection is performed in conjunction with an office visit on the same day. Payment will be made for the visit and the cost of the drug.

The appropriate level of E/M service should be reported in addition to the appropriate code for the drug. The administration service is considered to be part of the office visit.

Injection administration (procedure codes 90782-90784, 90788, and 90799) will be paid when billing independently, i.e., no E/M service is rendered on that day. In this case, one of the administration codes listed above should be billed in conjunction with the appropriate code for the drug.

Payment can be made for visits, the administration of the drug, and the cost of the drug for chemotherapy injections. Payment can also be made for the cost of the drug and a visit on the same day if the visit was for a separate and identifiable service, such as a history and physical to determine that arthrocentesis was needed.

*As reported in the August 1992 "Medicare Report," **payment will be made** for the vaccine administration and office visit for the pnuemoccal vaccine (90832) and the hepatitis B vaccine (90731).*

How should a major surgery performed within the post-operative period of a biopsy be billed to Medicare?

If a major surgery is performed on the same day or within the post-operative period of a biopsy, the major surgery should be billed with a "79" modifier.

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Charles W. Kinzer, M.D., P.A.
Internal Medicine Associates of Annapolis
Annapolis, MD

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Estate Planning: Some First Steps

Robert L. Lamb

After you've worked a lifetime to build an estate, it's possible for the federal government to snatch up to 55 percent of it away from your heirs, and this could happen even if you've made a will. Clearly, an estate not carefully and professionally planned is one destined for lawyers' pockets, the courts, and both federal and state taxes.

If you do not make a will, the courts, according to state law, will determine exactly who will receive funds from your estate and in what amounts. Generally the law of intestate succession applies to property not jointly titled. It provides for heirs through a formula which slightly favors the spouse and treats all children equally. In the event that the spouse is not a U.S. citizen, a different set of rules apply.

Why do some people fail to write a will? They mistakenly believe that the spouse automatically receives everything, or they speculate that joint ownership solves all problems. Many physicians avoid estate planning because they do not wish to deal with their own mortality while others simply procrastinate. However, when a person dies without a will, the heirs can expect to see the maximum amount of federal estate taxes levied on their legacy.

Objectives of estate planning

The objectives of estate planning usually begin with providing appropriate financial security for the surviving spouse and children. The plan which follows seeks to assure that the spouse will be able to maintain the accustomed standard of living and to educate the children.

• *Provide for liquidity to cover all death expenses and outstanding bills:* Today, as expensive as living is, it's a sad fact that the price of dying also has skyrocketed. This means that the surviving spouse will immediately need a significant amount of cash to cover funeral expenses, outstanding bills, and death taxes. Good estate planning assures access to some highly liquid assets.

• *Avoid probate:* While it's true that the cornerstone of estate planning is the will, it's also true that a will alone will not preserve a maximum amount of your estate for your heirs. Without additional planning, all of the assets of your estate will go through a lengthy and sometimes expensive court proceeding called probate. By the end of this process, as much as 10 percent of your estate can vanish into the legal system through administrative fees, executor fees, and legal fees.

• *Limit your estate to blood relatives:* In estate planning, through the use of trusts, it is possible to assure that intended funds only go to blood relatives, a detail which may be important in contemporary America with its serial families.

• *Protect your heir's inheritance:* Occasionally a parent detects a touch of the prodigal in a child, a condition which usually self-corrects given the passage of time. However, should this child receive a lump-sum inheritance too early in life, the entire legacy quickly could be squandered. In these situations a trust can manage the inheritance and pay it out in installments. Such an instrument also can be fine-tuned to give the trustee some discretion in the distribution of funds.

• *Provide for a handicapped person:* Unless special provision is made, the law will treat all children equally. But, in fact, there may be a special-needs child in your family, someone with a disability who will require expensive care for a protracted period. Estate planning can assure that assets are dedicated to this person's care. Alternatively, a carefully crafted estate plan will insure that a child's eligibility for government-funded assistance or programs is not affected by an inheritance from your estate.

• *Avoid or reduce estate taxes:* When Benjamin Franklin said only death and taxes are certain, he didn't go quite far enough. Not only are death and taxes certain but so also are death taxes. If ever there was taxation without representation, estate and inheritance taxes are it. While a surviving spouse usually can re-

Mr. Lamb is planned giving officer for the Society's Educational and Scientific Trust.

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NOVEMBER 1992

November 4, 1992
HYPOTHYROIDISM: PATHOGENESIS AND IMMUNE MECHANISMS
E. Chester Ridgway, III, M.D.
Professor of Medicine
Head, Division of Endocrinology
University of Colorado Health Science Center
Denver, CO

November 11, 1992
LV REMODELING: CELLULAR AND THERAPEUTIC CONSIDERATIONS
Gary S. Francis, M.D.
Professor of Medicine
Cardiovascular Division
University of Minnesota School of Medicine
Minneapolis, MN

November 18, 1992—Grand Rounds
IMMUNOLOGIC INTERVENTIONS FOR RHEUMATOID ARTHRITIS: FROM FALLACIOUS TO EMPIRIC TO TARGETED APPROACHES
David E. Trenthan M.D.
Associate Professor of Medicine
Harvard Medical School
Chief, Division of Rheumatology
Beth Israel Hospital
Boston, MA

November 25, 1992
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December 2, 1992
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Ronald Simon, M.D.
Associate Clinical Professor of Medicine & Pediatrics
University of California/San Diego School of Medicine
Head, Division of Allergy & Clinical Immunology
Scripps Clinic and Research Foundation
La Jolla, CA

December 9, 1992
CHOLESTEROL REDUCTION IN PRIMARY PREVENTION: UNANSWERED QUESTIONS AND UNQUESTIONED ANSWERS
Jeremy Swan, M.D., Ph.D.
Professor of Medicine
UCLA School of Medicine
Los Angeles, CA

EARLY STAGE BREAST CANCER: PATIENT SELECTION CONTROVERSIES
Michael P. Moore, M.D., Ph.D.
Assistant Professor of Surgery
Cornell University School of Medicine
Attending Surgeon,
Memorial Sloan-Kettering Cancer Center
New York, NY

December 16, 1992
BIOLOGICAL FACTORS OF BREAST CANCER: EARLY DIAGNOSTIC AND PROGNOSTIC INDICATORS
Nancy Davidson, M.D.
Assistant Professor of Oncology
Johns Hopkins Cancer Center
Johns Hopkins School of Medicine
Baltimore, MD

December 23, 1992
Christmas Holidays – No Grand Rounds

Hahnemann University Department of Medicine
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8:30 a.m.-3:30 p.m.

November 18, 1992
MECHANISMS AND STRATEGIES FOR TREATING AUTOIMMUNE DISEASES
Course Director: Richard L. Spielvogel, M.D.
Guest Faculty: Alice Gottlieb, MD
Richard P. MacDermott, M.D.
David E. Trenthan, M.D.

December 2, 1992
ASTHMA
Course Director: David M. Lang, M.D.
Guest Faculty: Ronald Simon, M.D.

December 16, 1992
BREAST CANCER: DIAGNOSIS AND TREATMENT
Course Codirectors: Jeffrey Brodsky, M.D.
Pamela Crilley, D.O.
Guest Faculty: Nancy Davidson, M.D.
Michael P. Moore, M.D., Ph.D.

Seminar Director:
Allan B. Schwartz, M.D.
Professor and Vice Chairman of Medicine
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ceive all of the assets of the estate free of estate taxes, the tax collector is assured of getting a portion upon the death of that spouse. Assets above the $600,000 exemption will be taxed before going to the heirs, and in the case of a physician's estate, will be taxed at the minimum 37 percent rate just on the federal estate tax. Depending on the size of the estate, the federal tax quickly climbs to a 55 percent tax rate.

An estate plan that utilizes two trusts—one which takes advantage of the federal estate tax credit and the other that preserves the marital deduction—can pass assets to your heirs at the least tax cost.

Establishing the estate plan best for you and your family requires time with your attorney and financial planner, but compared to not having a proper plan, the procedure is relatively inexpensive.

Reexamination of changes

Many physicians treat estate planning as a once-in-a-lifetime event. Such an attitude can produce disastrous surprises for the surviving spouse and heirs. For example, could a problem at the office affect the future of your family? Yes indeed!

Unresolved disputes among partners, particularly relating to buy-out provisions, could have a devastating effect on your estate and create grievous problems for your family. Examples of other common events which have an impact on estate plans include: receipt of a gift or inheritance, changes in property values, and/or changes in tax laws.

Life is a panoply of birth, death, marriage, divorce, illness, educational needs, maturity of family members, and practice change—any one of which can trigger a significant change in an estate plan. And when a change occurs, reexamination of the plan is essential.

Charity as an estate-planning tool

There is no right or wrong way to manage your estate; the options are numerous. What is needed is quality time for you and your spouse to plan the scenario you envision. Estate planning is not a euphemism for "death" inasmuch as some aspects of estate planning will become part of your retirement plan.

For example, it is not uncommon for a physician to own stock which has been held for a long time and which, although performing poorly in terms of dividends, has significantly appreciated in value. The challenge here is to avoid the capital gains tax. This can be accomplished by setting up a charitable remainder annuity trust or charitable remainder unitrust, or by purchasing a gift annuity from a charity such as the Medical Legacy Fund of the Society's Educational and Scientific Trust. You would establish a guaranteed income for life and avoid the capital gains tax.

In the transaction, the Medical Legacy Fund would sell the original stock and reinvest the proceeds in better performing instruments, thus assuring more income. In this scenario the charity is not required to pay capital gains tax on the sale and neither are you, the donor. Instead, in giving the stock you would take a substantial charitable gift deduction on your federal income tax and even receive some of your Medical Legacy Fund income tax free. Nor would the stock still be part of your estate for estate tax purposes.

In such a transaction, some donors choose to purchase a life insurance policy or establish a trust, funded by life insurance, in the amount of the contribution to the charity. The children are designated as owners and beneficiaries, and the savings derived from avoiding the capital gains tax are used to pay the policy premium. For the heirs, the death benefit replaces the money given to the charity.

Importance of using expert advisors

Like anything else, estate planning requires a serious investment of time and money. It is a joint enterprise for the physician and spouse in which numerous options must be weighed. Experts who contribute to a well-rounded estate plan include attorneys, tax advisors, financial planners, and life insurance experts.

This article is not intended to be a definitive guide to estate planning. Physicians should consult with professionals of their choice to formulate their own personal estate plans, and then review them periodically.

Free Estate Planning Pamphlets Available

For the free booklets: "Is Your Will Obsolete?" and "Estate Planning," send the coupon below to the Trust's Medical Legacy Fund or call Bob Lamb, planned giving officer, toll free at 1-800-228-7823.

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ASSESSING THE IMPACT OF RBRVS ON REVENUES

As the first transition year of the Medicare fee schedule under the resource based relative value system (RBRVS) comes to a close, physicians are focusing on key issues for the year ahead, including financial planning and participation status in Medicare.

In reviewing 1992, many physicians may be surprised to find that the effect of the fee schedule was not as dramatic as had been predicted. Depending on the specialty and patient mix, some practices felt its impact more than others. In preparing a 1992 budget, physicians can begin by basing financial planning on the existing conversion formula to estimate Medicare income. However, as of this writing, the final conversion formula is still being debated.

Keeping abreast of this decision and other RBRVS trends will be critical to physicians' planning throughout the year. A business plan or financial budget should not only be periodically reviewed, but should be updated to reflect any changes.

The impact

The following are examples of fee schedule changes that may have implications on a practice's income and—ultimately—the bottom line:

- Physicians will continue to receive less reimbursement when performing typical office procedures in hospital outpatient settings rather than in their offices. The Health Care Financing Administration (HCFA), having applied a special reduction in payment for these services because part of the overhead is absorbed by the hospital, has recently decided to exclude some 50 procedures when performed in ambulatory surgical centers rather than in offices. This rule could apply to some services physicians are currently performing. To account for such changes in a budget, physicians can refer to the carrier's Medicare bulletin for a complete list of such procedures.
- In response to physicians' objections that new reimbursement levels were not equitable, HCFA has recalculated fees for a number of procedures. If a practice is considering the purchase of major capital equipment for these procedures, the return on investment may be significantly affected.
- A new physician added to a practice in 1993 will be subject to reimbursement discounts if he or she does not have a billing history. As of this writing, a first-year physician is allowed 80 percent of the new par or non-par fee; second-year physician—85 percent; third year—90 percent; and fourth year—95 percent. HCFA has also clarified the definition of a "new physician." Effective January 1, 1991, the first year of practice is considered to be the first year during which services were rendered to Medicare patients during January of that year. This means that a physician must have been billing Medicare for a service rendered in January 1991 for 1991 to have been considered the first year of practice.

A physician's financial analysis should also include monitoring other practice trends, including changes in demographic data. Reviewing these trends can provide valuable information as to whether a physician's Medicare population is expanding or decreasing. One implication of changing demographics may be to bolster a physician's marketing efforts to expand his or her patient base in the younger population segment.

Participation decision

In designing a 1993 budget, physicians will inevitably be faced with the issue of their participation status. This year marked a record participation rate of 55 percent. In fact, according to a recent HCFA study, over the last five years the percentage of physicians electing to participate in Medicare has steadily risen in specialties such as internal medicine, orthopedic surgery, ob/gyn, general surgery, and family and general practices. This trend will most likely continue as the allowable non-par and par fees get closer each year.

Since the introduction of the Omnibus Budget Reconciliation Act in 1989, incentives for non-par physicians have increasingly diminished: this year, HCFA limited Medicare charges to 120 percent of prevailing charges; in 1993, the limit will drop to 115 percent. In addition, non-par physicians, opting to receive all reimbursement from patients, take on a greater risk of bad debts. Physicians electing not to participate may be giving up some intangible benefits as well, including public relations to patients and referring physicians or free government advertising.

When changing status from par to non-par, consider the ramifications of the alternatives: possible loss in patient volume and billing, and the need to assess options for generating income to compensate for lost revenues. Marketing strategies and communications efforts to attract new patients may need to take on heightened priorities. Central to this issue is the extent to which other insurance carriers will reimburse for the same procedures or services. Many third-party carriers are increasingly looking to the Medicare fee schedule as a model for their own reimbursement fees. Managed care contracts, for example, frequently do not offer a more attractive option.

The coding imperative

A key component of a physician's financial assessment should be a critical review of the practice's administrative routines—especially billing and coding procedures. With the constant changes imposed by HCFA, accurate and efficient coding has more than ever become an imperative. As the government continues to increase its staffing capacity to investigate physicians' compliance with Medicare, physicians should be dedicating resources to streamlining documentation routines.

To avoid claims of overpayment, a physician must ensure that coding procedures stringently comply with the HCFA guidelines. However, equally important is ensuring that all the Medicare revenues to which a physician is legally entitled are being received. A physician needs to know how to convert office procedures into CPT codes, and the billing staff must know how to convert that into prompt reimbursements.

As the first year of RBRVS comes to a close, physicians continue to be presented with multiple challenges—not only to make sure their paperwork is in order, but to streamline key practice management routines. As always, planning ahead is the key to meeting these challenges, and the time to start is now.

Patricia M. Salmon, Edward L. Grab
Consultants, The Health Care Group
Plymouth Meeting

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Wednesday, December 2, 1992

Premature Ventricular Beats: Benign vs. Life-Threatening Arrhythmias

Moderator: Francis E. Marchlinski, M.D.

3:00-3:30	The role of signal-averaging and holter monitoring; the interpretation of the PVC: In what company it keeps!	*Mark Preminger, M.D.*
3:30-4:00	Drugs vs. AICD vs. surgery for life-threatening ventricular arrhythmias	*Francis E. Marchlinski, M.D.*
4:00-5:00	Case Presentations	*Roman Pachulski, M.D.*
	Panel Discussion	*Charles D. Gottlieb, M.D.* *Joel Morganroth, M.D.* *Mark Preminger, M.D.* *Mark Rosenthal, M.D.*

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PRO Myths vs. Facts

Donald E. Harrop, MD

One thing of which the Keystone Peer Review Organization may be rightfully accused is that we are boastful about our efforts to communicate with physicians and providers. We think we do as good a job of education as can be done, and we don't mind saying so. However, certain myths have formed in the minds of some of our fellow physicians which seem impossible to dispel.

Based on correspondence I've received at the Keystone Peer Review Organization (KePRO), certain myths persist with physicians no matter how many times we have written or made presentations about the facts on these subjects. Although I hate to rehash the same old topics too many times, it may be worth trying once more.

Here are a few of the most prevalent erroneous beliefs and their clarifying facts:

Myth: PROs have quotas for denying admissions and for identifying quality problems.

Fact: As teenagers of today would say, "NOT!" PROs have no quotas, and the KePRO Board of Directors would probably tell the Health Care Financing Administration (HCFA) to keep their contract if they tried to force one on us.

Myth: KePRO physician advisors use criteria and generic quality screens to arrive at their review decisions.

Fact: Physician advisors are expected to use their own medical judgment and clinical experience to determine medical necessity of admissions and quality of care provided, and are strongly discouraged from referring to criteria and screens.

Myth: KePRO reviewers are not truly "peers."

Fact: During a recent study of statistics for a one-month period, review of inpatient cases was conducted by matching specialists better than 99 percent of the time for level I, II, and III reviews, and for reconsiderations. Specialty matches occurred in 81 percent of the ambulatory surgery cases reviewed, but one specialty, in which we have a shortage of physician advisors, accounted for approximately one-half of the cases in which there was no match.

Myth: KePRO non-physician review personnel make medical judgment determinations.

Fact: Nonphysician reviewers may approve cases which meet criteria and pass generic quality screens, but they must refer all other cases to a physician advisor for a decision.

Myth: KePRO personnel consult DRG weight tables and only refer cases for review for a lower weighted DRG change.

Fact: The objectives of DRG validation are accuracy, consistency, and fairness, not cost containment; therefore, the number of cases which KePRO upgrades may surprise some people. For example, during the period of October 1, 1990, through September 30, 1991, DRGs that were changed were assigned a higher weighted level in 44 percent of cases as opposed to 56 percent that were downgraded.

Myth: KePRO reports findings to the National Practitioner Data Bank.

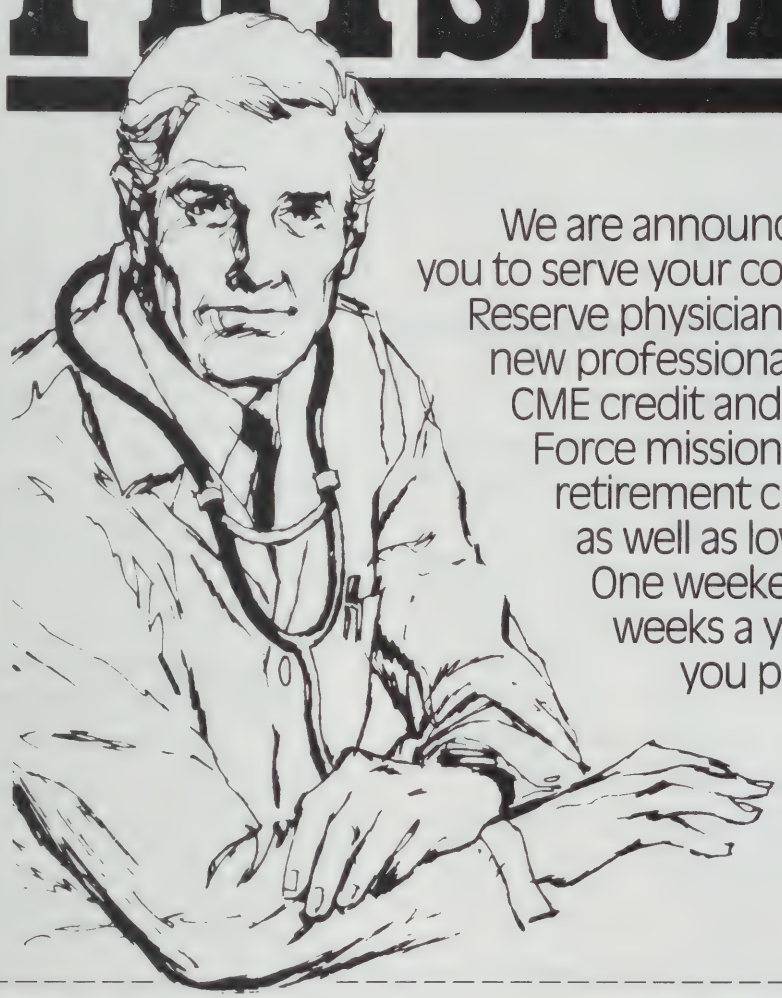
Fact: There are no requirements for PROs to report to the National Practitioner Data Bank. Actually, there have been no methods provided for them to do so even if they felt it was appropriate.

As you might imagine, these misconceptions cause some problems, but actually I feel sorrier for the physicians who believe them. It would certainly add to the frustration level to receive a letter from KePRO and be cited for a quality problem while believing that the review was conducted by someone who is not a peer or even a physician, or that an adverse decision was made to meet a quota.

Think about this the next time one of your colleagues is complaining about KePRO and is referring to one of the above myths. Perhaps you can help to reduce their frustration level by presenting the facts.

Dr. Harrop is president of the Keystone Peer Review Organization.

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SOCIETY MEMBERSHIP INCREASES, '93 PLAN SET

Pennsylvania Medical Society membership is now 21,111, a 3.7 percent increase from this time last year. The increased figure can be attributed to the 1992 recruitment and retention plan of the Society's Council on Membership, which focused on 12 Pennsylvania counties. The 1993 plan, however, is taking a new approach.

"The 12-county approach has been used for several years now," said Wilma Light, MD, council chairman. "In order to address concerns and issues pertinent to segments of physicians that have not received as much attention in past recruitment efforts, we're taking a new approach." The 1993 recruitment plan places a greater emphasis on several groups—group practices, women physicians, and international medical graduates (IMGs), as well as residents and students—and focuses on the state's 31 staffed county medical societies.

Recruitment activities will include: direct-mail marketing, phone-a-thons, peer-to-peer contact at the county level, and communication on issues of concern to emphasized groups. County societies, which will play a large role in this plan, will also be focusing on communication of special-interest issues.

Group practice

Aware that approximately 40 percent of Pennsylvania physicians practice in group settings, according to AMA statistics, the Society plans to include recruitment of medical group practices as an integral part of its 1993 plan. These efforts, with AMA cooperation, actually were launched during 1992 with the hiring in June of a group practice coordinator to serve as a liaison between group practices and the Society.

The AMA's involvement with group practice membership has been on-going for the past few years. Because of the success of a pilot project in Wisconsin, the AMA is partially funding group practice coordinator positions in Pennsylvania and Ohio. Two other regions in the country will have coordinators by the end of the year.

The Pennsylvania Medical Society's group practice coordinator works closely with the Group Practice Advisory Committee, established by Society Executive Vice President Roger F. Mecum last spring. The committee—comprised of administrators from various groups, including Geisinger Clinic, Guthrie Clinic, Penn Group Medical Associates, University of Pittsburgh, Thomas Jefferson University, Bryn Mawr Medical Specialists, A.Z. Ritzman Associates, and Cowley Associates—has met three times to discuss their concerns, which range from differing group needs to communication issues.

> ***"The 12-county approach has been used for several years now. In order to address concerns and issues pertinent to segments of physicians that have not received as much attention in past recruitment efforts, we're taking a new approach."***
>
> *Wilma Light, MD*
> *Chairman, Council on Membership*

By analyzing the information and opinions which come out of the committee, the Society has gained a greater understanding of the needs of group practices. The Society will continue to work with county medical societies and the Department of Physician Services to create services to better address those needs.

Dues restructuring

One final area of focus by the Council on Membership in 1993 will be to study the Society's dues structure. The council believes that the collection process may need revision to be more effective and efficient, and that such revision could possibly save the Society money.

Specifically, the council will study the length and time of the billing cycle; the mechanisms within the cycle, including electronic funds transfer, credit card payment, and quarterly payment options; and the use of other mechanisms, such as various discounts and a corporate or institutional dues structure. The council hopes to present results of its study to the Society's Board of Trustees in the first half of 1993 and recommendations to the House of Delegates at its 1993 annual meeting.

SOCIETY, STATE DEVELOPING "YOUTH AGAINST TOBACCO"

The State Society and the Pennsylvania Departments of Health and Education are working jointly to develop a statewide "Youth Against Tobacco" campaign.

Tobacco is the leading preventable cause of death in the United States, killing nearly 500,000 Americans each year; about 90 percent of all smokers began smoking before age 18.

The campaign will focus on promoting a tobacco-free society and encouraging youths to take an active role in promoting a "no-use" message about tobacco. A variety of activities are planned throughout the school year, including:

- a pledge campaign, aimed at urging students to sign a pledge card against tobacco use;
- distribution of facts—suitable for classroom use—about smoking, smokeless tobacco, and second hand smoke;
- a tobacco control contest; and
- a media campaign.

Campaign promotional materials, such as bookmarks, book covers, flyers, etc., were sent to Pennsylvania's school superintendents in conjunction with the Great American Smokeout this month.

For more information about the Youth Against Tobacco campaign, call the Pennsylvania Department of Health at 1-800-692-7254.

COUNTY NEWS

SOCIETY LAUNCHING PILOT REFERRAL NETWORK

New efforts are being launched to link physicians with the state's Medicaid beneficiaries and uninsured patients. The Society in early October announced a program

to recruit physicians in Lackawanna County for a pilot physician referral network project.

The Society developed a computer network system to link participating hospital emergency departments and a list, by specialty, of local volunteer physicians. When Medicaid beneficiaries or uninsured patients need a physician or are in the emergency room for non-emergency services, hospitals can tap into the computer network to get a referral.

Patients, hospitals, and physicians will receive a paper copy of the referral to help track the program's effectiveness. To fairly distribute the uninsured and Medicaid patient base, physician's names are rotated to the bottom of the list after each referral. Physicians who volunteer to participate in the program agree to see patients within 72 hours, accept the discounted Medicaid payments, provide a reduced charge for the uninsured according to the patient's ability to pay, and stay in the pilot for six months.

The Lackawanna County Medical Society's role is two-fold: 1) joining the State Society in contributing financial, computer, and staff resources, as well as ombudsman services to complement the project; and 2) running the initial physician referral pilot, which is expected to be a prototype for the state.

Allegheny County is the next county slated to begin installation of a network. A more complex Lancaster County pilot program, which includes a managed care initiative, is awaiting federal approval to start up.

CANADIAN PHYSICIAN SPEAKS TO COUNTY GROUP

Nick Gettas, MD, a London, Ontario, family physician and president of the London Academy of Medicine, was the guest speaker at the September meeting of the Mercer County Medical Society. Dr. Gettas spoke about the deterioration of Canada's health care system.

According to Dr. Gettas, Canadian physicians and patients alike are frustrated with the system. Presently, the following has occurred:

- delisting of certain covered services, similar to Medicare's recent elimination of consultations for surgical clearance and/or management of established patients;
- curtailing health coverage for Canadians vacationing outside their country;
- capping physicians' incomes; and
- closing hospital beds.

For the future, Dr. Gettas has predicted: growing waiting lists, decreasing availability of physicians, increasing numbers of physicians leaving Canada, and increasing outpatient procedures.

The Canadian system of health care "has always prided itself on having availability equally to everyone," Dr. Gettas said, but he now sees that as changing.

Dr. Gettas also spoke about long term care as one of Canada's major problems. Coverage only lasts for 120 days, he explained, and waiting lists are up to a year long. According to Joseph A. Giordano, MD, specialist in internal medicine, Sharon, "His basic message was that Canadian health care is not covered 'from the cradle to the grave' as so many people believe." Dr. Gettas' hour-long speech "was received most positively" by approximately 100 attendees at the meeting, Dr. Giordano said.

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Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

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Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

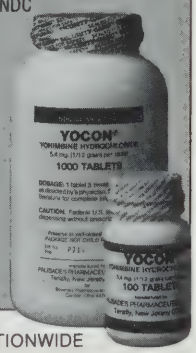
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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NEW PRESIDENT APPOINTS COUNCILS, COMMISSIONS

State Society President Donald G. Ferguson, MD, has appointed the following physicians as members and officers of the Society's councils, commissions, and committees for the 1992-93 term:

Council on Education and Science
Chairman Blairanne H. Revak, MD (Columbia); Vice Chairman Richard D. Baltz, MD (Dauphin); Mary Jo Bonner, MD (Berks); David R. Brill, MD (Montour); Gene L. Cary, MD (Dauphin); Charles J. Cattano, MD (Allegheny); Richard L. Decker, MD (Blair); John J. Dennehy, MD (Montour); Robert J. Fagioletti, MD (Washington); Joseph A.C. Girone, MD (Bucks); Stanley P. Mayers Jr., MD (Centre); John H. Moyer, MD (Cambria); Tomas A. O'Boyle, MD (Lackawanna); R. Douglass Ross, MD (Philadelphia); Morgan T. Smith Jr., MD (Montgomery) Russell J. Stankiewicz, MD (Union); Frederick S. Sunderlin Jr., MD (Montour); Carol Lynn Trippitelli (Dauphin).

Commission on Bioethics
Chairman Mary Jo Bonner, MD (Berks); Vice Chairman David Turkewitz, MD (Montour); Raymond A. Capone Jr., MD (Allegheny); James F. Crispen, MD (Dauphin); Francis C. Donovan, MD (Allegheny); George D. Hanzel, MD (Cambria); Russell J. Stankiewicz, MD (Union); Frank J. Tornetta, MD (Montgomery); Theresa A. Walls, DO (Lancaster).

Commission on Environmental and Occupational Health
Chairman David R. Brill, MD (Montour); Vice Chairman Nancy S. Nieland, MD (Allegheny); James L. Harrison, MD (Lycoming); Joseph Schwerha, MD (Allegheny); Thomas B. Scott, MD (Bradford); Theodore F. Them, MD, PhD (Bradford); Louis VandeBeek, MD (Philadelphia).

Commission on Licensure and Practice of Health Care Professions
Chairman Robert J. Fagioletti, MD (Washington); Vice Chairman Richard T. Bell, MD (Berks); Sucha O. Asbell, MD (Philadelphia); Bradley J. Bradford, MD (Allegheny); Frederick B. Doerfler Jr., MD (Armstrong); Christopher W. Fellin, MD (Montour); William W. Lander, MD (Montgomery); Robert G. Sanford, MD (Dauphin).

Commission on Medical Education
Chairman Charles J. Cattano, MD (Allegheny); Vice Chairman Bradford K. Strock, MD (Dauphin); Robert C. Aber, MD (Dauphin); Paul W. Dishart, MD (Allegheny); Carmela F. deRivas, MD (Montgomery); Joyann A. Kroser, MD (Philadelphia); Vahaken Tachdjian, MD (Philadelphia); Carol Lynn Trippitelli (Dauphin).

Commission on Public Health
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Subcommittee on AIDS
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Subcommittee on Continuing Medical Education
Chairman Carl A. Frankel, MD (Dauphin); James L. Cosgrove, MD (Allegheny); Joseph M. Daday, MD (Clarion); Dean F. Dimick, MD (Lehigh); Walter I. Hofman, MD (Montgomery); Earl R. Miller, MD (Lycoming); Robert S. Pyatt Jr., MD (Franklin).

Council on Medical Practice
Chairman Diehl M. Snyder, MD (Lebanon); Vice Chairman Barbara E. Barnes, MD, (Erie); Alan J. Barnett, MD (Allegheny); Jeffrey H. Chaby, DO (Lancaster); Gordon H. Clark Jr., MD (Erie); Ronald J. Clearfield, MD (Westmoreland); Robert M. Haddad, MD (Montour); John P. Pagana, MD (Northumberland); James G. Pitcavage, MD (Allegheny); Fred Teichman, MD (Union); Ira H. Weiner, DO (Delaware); Edward M. Zimmerman, MD (Beaver).

Council on Governmental Relations
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Council on Medical Economics
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Commission on Access to Health Care
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Council on Membership
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Advisory Committee on Professionalism
Chairman Ferdinand L. Soisson Jr., MD (Cambria); Alan L. Dorian, MD (Montgomery); Syed R. Hussaini, MD (Allegheny); Matthew Marshall Jr., MD (Allegheny). *Note: State Society secretary serves as chairman of this committee.*

OBITUARIES

B. Irene Armstrong, *St. Marys*
University of Pittsburgh School of Medicine, 1947; age 74, died June 27, 1992. Dr. Armstrong specialized in ophthalmology.•

James A. Batts Jr., *Philadelphia*
Howard University, 1941; age 78, died August 22, 1992. Dr. Batts was a obstetrician/gynecologist.•

Russel A. Boykiw, *Clearfield*
Hahnemann Medical College, 1946; age 82, died September 4, 1992. Dr. Boykiw was a family practitioner.•

Gerald E. Callery, *Malvern*
Jefferson Medical College, 1943; age 76, died September 7, 1992. Dr. Callery was an orthopedic surgeon.•

Joseph S. Corba, *Pittsburgh*
Hahnemann Medical College, 1935; age 84, died August 18, 1992. Dr. Corba was a general practitioner.•

James L. Harrison, *Williamsport*
Hahnemann Medical College, 1951; age 68, died September 8, 1992. Dr. Harrison specialized in thoracic surgery.•

Gerald T. Lorentz, *McConnellsburg*
Hahnemann Medical College, 1943; age 77, died August 25, 1992. Dr. Lorentz was a general practitioner.•

Martin A. Myers, *Philadelphia*
Temple University, 1937; age 82, died June 21, 1991. Dr. Myers was a general practitioner.•

Joseph J. Newhouse, *Belle Vernon*
St. Louis University, 1953; age 66, died September 13, 1992. Dr. Newhouse was a general practitioner.•

Nathan W. Rubin, *Norristown*
McGill University, 1927; age 88, died August 25, 1992. Dr. Rubin specialized in obstetrics/gynecology.•

Morris H. Samitz, *Philadelphia*
Temple Medical School and the Penn Graduate School of Medicine, 1933; age 82, died August 22, 1992. Dr. Samitz specialized in dermatology.•

Edward J. Sarp, *Duncansville*
Georgetown Medical School, 1952; age 65, died August 29, 1992. Dr. Sarp specialized in geriatrics and was the medical director at Hollidaysburg Veterans Home.•

Spencer J. Servoss, *Williamsport*
Georgetown University Medical School, 1937; age 81, died August 29, 1992. Dr. Servoss specialized in urology.•

Jack R. Wennersten, *Pottstown*
Jefferson Medical College, 1939; age 80, died September 1, 1992. Dr. Wennersten was a general practitioner.•

Arthur G. Cannon, *Greensburg*
Pittsburgh Medical School, 1947; age 69, died September 7, 1992. Dr. Cannon was a pediatrician.

Thelma L. Dulany, *McKeesport*
Western Reserve and University of Pittsburgh, 1933; age 83, died August 18, 1992. Dr. Dulany was an ophthalmologist.

Thomas J. Lewis, *Cecil Township*
University of Pennsylvania Medical School, 1930; age 86, died August 11, 1992. Dr. Lewis specialized in urology.

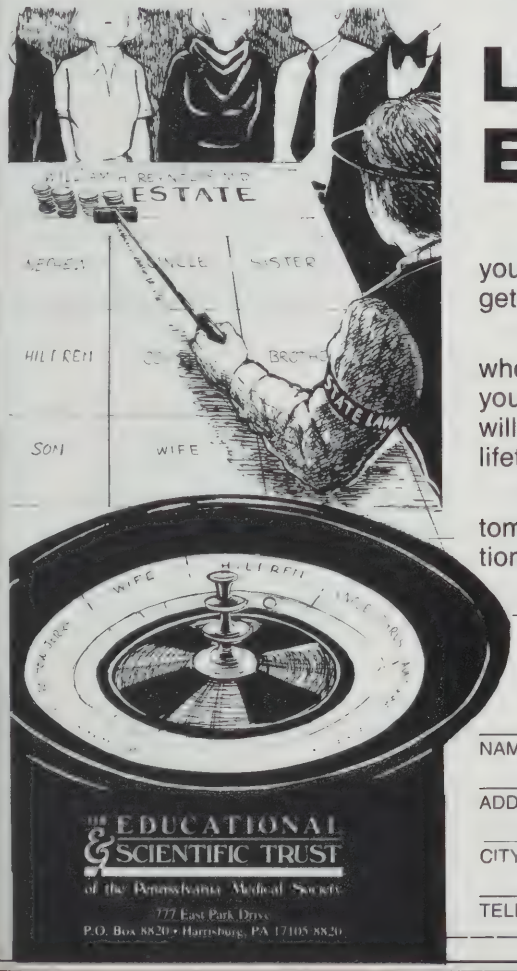
George L Neumann, *Old Forge*
Columbia University School of Physicians and Surgeons, 1924; age 92, died July 23, 1992.

William L. Silverman, *Wynnewood*
Philadelphia College of Osteopathic Medicine, 1938; age 80, died August 10, 1992. Dr. Silverman specialized in pathology.

Calvin C. Weidner, *Peoria, AZ*
Hahnemann University Medical School, 1954; age 67, died August 6, 1992. Dr. Weidner specialized in occupational medicine.

J. Louis Wilkerson, *Newtown Square*
Bowman Gray School of Medicine, 1943; age 72, died June 28, 1992. Dr. Wilkerson specialized in urology.

• Denotes membership in the Pennsylvania Medical Society at the time of death.



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Joseph G. English, MD, chief emergency services physician, Williamsport Hospital and Medical Center, and vice president and charter member of the Emergency Care Physicians Association, has been appointed vice president/ medical director, Williamsport Hospital and Medical Center.


Dr. Regan

James D. Regan, MD, Society trustee and chairman of the Long Range Assessment Committee, served as a representative of the Society on a panel at the First Annual Legislative Health Care Forum held in Chester County in October by **Representative Elinor Z. Taylor** (R).

David Soll, MD, Rydal, received the Senior Honor Award, the highest honor bestowed by the American Academy of Ophthalmology for public and professional service.

Kenneth D. Cohen, MD, senior attending physician at Belmont Center for Comprehensive Treatment, Philadelphia, was named Practitioner of the Year by the Philadelphia Psychiatric Society. **Alexander D. Almeyda, MD,** Albert Einstein Medical Center resident, was named Resident of the Year.

Nathaniel H. Mayer, MD, founder and director, Drucker Brain Injury Center, Moss Rehabilitation Hospital, Philadelphia, and professor of rehabilitation medicine, Temple University, received the Individual Distinguished Service Award from the Pennsylvania Association of Rehabilitation Facilities.

Robert L. Boyd, MD, specialist in internal medicine and oncology, Delaware County Memorial Hospital, Drexel Hill, and **Donald D. Douglas, MD, FACP,** gastroenterologist, Evangelical Community Hospital, Lewisburg, have been elected to fellowship in the American College of Physicians.

Edwin D. Arsht, MD, received the Distinguished Service Award in Medical Education from Delaware County Memorial Hospital's graduating residency class of 1992, Department of Family Practice, for "excellence and outstanding service as a teacher in the specialty of family practice."

Lila Stein Koser, MD, a family physician in northeast Philadelphia, has been elected president of the Family Health Foundation of Pennsylvania, Inc., the philanthropic arm of the Pennsylvania Academy of Family Physicians. Her daughter, **Joyann A. Koser, MD,** a third-year internal medicine intern at The Medical College of Pennsylvania, was selected by the American College of Physicians to serve a two-year term on the National Council of Associates.

Alan M. Laties, MD, professor of ophthalmology, University of Pennsylvania School of Medicine, Scheie Eye Institute, Philadelphia, received the Paul Kayser International Award of Merit at the International Congress of Eye Research in Stressa, Italy, for his pioneering work in basic research on retinal neurotransmitters and the influence of the retina on eye growth.

Marvin Steinberg, MD, vice chairman of the Department of Orthopedic Surgery and director of the Hip Clinic and the Joint Reconstruction Center at the University of Pennsylvania Medical Center, presented "Effects of Electric and Electromagnetic Fields on Bone Formation, Bone Circulation, and Avascular Necrosis" at an Association Research Circulation Osseous post-graduate course in Brussels, Belgium, in September.

Edward Leonard Jr., MD, senior psychiatrist, Friends Hospital, Philadelphia, and clinical assistant professor of psychiatry and human behavior, Jefferson Medical College, was awarded the Daniel Blain Award by the Philadelphia Psychiatric Society for his dedication and service to the profession of psychiatry.

Robert Ryan Clancy, MD, associate professor of neurology and pediatrics, University of Pennsylvania School of Medicine, Philadelphia, and co-director, Comprehensive Epilepsy Center, Children's Hospital of Philadelphia, has been elected to the Professional Advisory Board of the Epilepsy Foundation of America.



David S. Smith, MD (second from right), professor emeritus of pediatrics, Temple University School of Medicine, received the First Annual Albert J. Finestone, MD, Award for Excellence in Continuing Medical Education for his commitment to lifelong learning in the medical profession. The award recognizes the contribution of Dr. Finestone (center), who retired as associate dean for continuing medical education at Temple in 1991. Pictured (left to right) are: Robert R. Smedley, EED, assistant dean for medical continuing education, Temple; Richard J. Kozera, MD, associate dean, Temple University School of Medicine; Dr. Finestone; Dr. Smith; and Iain F.S. Black, MD, Waldo E. Nelson professor of pediatrics, Temple University School of Medicine.

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Ophthalmology	Michigan	$ 700,000
Ophthalmology	New Jersey	$ 300,000
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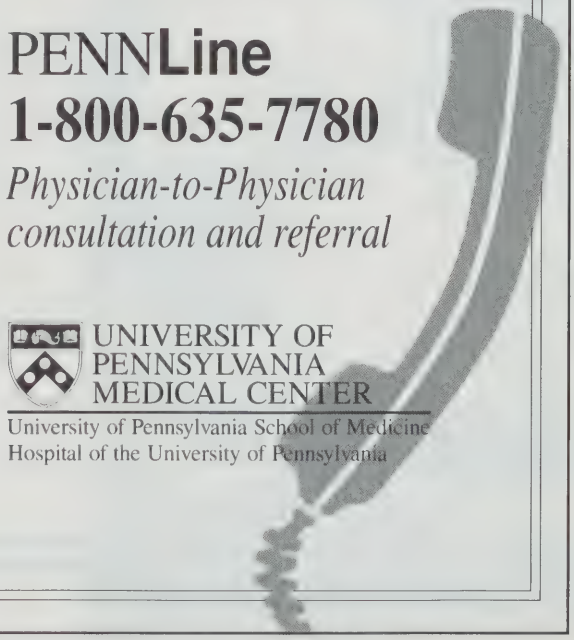
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Western Pennsylvania—Board Certified or prepared emergency physicians needed for staffing a community hospital emergency department near the Ohio/Pennsylvania border. Please send CV to P.O. Box 99431, Pittsburgh, PA 15233-0431.

Pennsylvania—Physician group seeks full-time and part-time physicians for an emergency department of community hospitals in central and western Pennsylvania. Please send resume to P.O. Box 99431, Pittsburgh, PA 15233-0431.

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Pocono Mts. area—Northeast Pennsylvania busy family practice looking for BE/BC family practitioner. No OB; active hospital practice; partnership possibilities. Skiing, boating, hiking within 5 miles. 90 minutes from Manhattan and Philadelphia. Please send CV to: Monroe Family Practice Assoc., 1803 W. Main, Stroudsburg, PA 18360; (717) 421-0170.

Immediate position—Part-time BC/BE internist. Southwestern Pennsylvania (suburb of Pittsburgh); ideal position for female physician desiring to raise a family and practice medicine. Modern new facility, x-ray, lab. Salary negotiable. Box 366, PENNSYLVANIA MEDICINE, 777 East Park Dr., P.O. Box 8820, Harrisburg, PA 17105-8820.

Seeking associate for busy family practice in western Pennsylvania area. Salary and benefits guaranteed with full partnership available in one year. Transportation and accommodations paid for meeting. Contact Chris at (412) 758-7524 or reply to U.G. Kim, MD, P.O. Box 868, Ellwood City, PA 16117.

Wanted—Family physician needed for busy broad based group practice 35 minutes north of Pittsburgh. Practice includes obstetrics, nursing home work, house calls, and assisting in surgery. Contact: Family Medical Care Associates (412) 681-5170.

Part-time emergency room position available in a 400-bed suburban hospital with 48,000 visits. Board certified/eligible in emergency medicine or other specialty with emergency room experience. Excellent salary package with partnership potential. Contact Clarke Hankey, MD, Emergency Department, St. Clair Hospital, 1000 Bower Hill Road, Pittsburgh, PA 15243 (412) 561-4900.

Pittsburgh, Pennsylvania—Penn Group Medical Association (PGMA), a multi-specialty group practice affiliated with the largest HMO in Pittsburgh, is seeking BE/BC physician in: family practice, internal medicine, pediatrics, ob/gyn, and psychiatry. We are formally affiliated with major teaching hospitals and leading community hospitals in Pittsburgh. PGMA serves eight ambulatory care centers, all conveniently located near cultural, educational, recreational, and corporate activities. Excellent salary, fringe benefits, and incentives. For confidential consideration contact: Angela Lascola, HealthAmerica, 5 Gateway Center, Pittsburgh, PA 15222 or call collect (412) 553-7502.

OB/GYN, FP, Perinatal, Neurology, Ortho, ID, Urol. Local opportunities. Contact Yannelli, Randolph & Co., 994 Old Eagle School Rd., Suite 1020, Wayne, PA 19087; 215-964-1616.

Physicians Wanted—Endocrinologist, Family Practitioner, Ophthalmologist, Otolaryngologist, Orthopedic Surgeon, Pediatrician, Psychiatrist - 20 miles northeast of Pittsburgh - professional center, Tarentum, PA; (412) 224-4663.

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(Required by 39 U.S.C. 3685)

1A. Title of Publication	1B. PUBLICATION NO.	2. Date of Filing
Pennsylvania Medicine	0 0 3 1 4 5 9 5	10-9-92
3. Frequency of Issue: Monthly	3A. No. of Issues Published Annually: 12	3B. Annual Subscription Price: $20.00

4. Complete Mailing Address of Known Office of Publication *(Street, City, County, State and ZIP+4 Code) (Not printers)*
777 East Park Drive, P. O. Box 8820, Harrisburg, PA 17105-8820

5. Complete Mailing Address of the Headquarters of General Business Offices of the Publisher *(Not printer)*
777 East Park Drive, P. O. Box 8820, Harrisburg, PA 17105-8820

6. Full Names and Complete Mailing Address of Publisher, Editor, and Managing Editor *(This item MUST NOT be blank)*

Publisher *(Name and Complete Mailing Address)*
Pennsylvania Medical Society
777 East Park Drive, P. O. Box 8820, Harrisburg, PA 17105-8820

Editor *(Name and Complete Mailing Address)*
John W. Mills, M.D., 590 Indian Spring Road, Indiana, PA 15701

Managing Editor *(Name and Complete Mailing Address)*
Elaine S. Herrmann
777 East Park Drive, P. O. Box 8820, Harrisburg, PA 17105-8820

7. Owner *(If owned by a corporation, its name and address must be stated and also immediately thereunder the names and addresses of stockholders owning or holding 1 percent or more of total amount of stock. If not owned by a corporation, the names and addresses of the individual owners must be given. If owned by a partnership or other unincorporated firm, its name and address, as well as that of each individual must be given. If the publication is published by a nonprofit organization, its name and address must be stated.) (Item must be completed.)*

Full Name	Complete Mailing Address
Pennsylvania Medical Society	777 East Park Drive P. O. Box 8820 Harrisburg, PA 17105-8820

8. Known Bondholders, Mortgagees, and Other Security Holders Owning or Holding 1 Percent or More of Total Amount of Bonds, Mortgages or Other Securities *(If there are none, so state)*

Full Name	Complete Mailing Address
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9. For Completion by Nonprofit Organizations Authorized To Mail at Special Rates *(DMM Section 424.12 only)*
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[X] (1) Has Not Changed During Preceding 12 Months [ ] (2) Has Changed During Preceding 12 Months *(If changed, publisher must submit explanation of change with this statement.)*

10. Extent and Nature of Circulation *(See instructions on reverse side)*	Average No. Copies Each Issue During Preceding 12 Months	Actual No. Copies of Single Issue Published Nearest to Filing Date
A. Total No. Copies *(Net Press Run)*	20,979	21,000
B. Paid and/or Requested Circulation 1. Sales through dealers and carriers, street vendors and counter sales	---	---
2. Mail Subscription *(Paid and/or requested)* Nonmembers included in dues	352 20,164	352 19,994
C. Total Paid and/or Requested Circulation *(Sum of 10B1 and 10B2)*	20,516	20,346
D. Free Distribution by Mail, Carrier or Other Means Samples, Complimentary, and Other Free Copies	270	274
E. Total Distribution *(Sum of C and D)*	20,786	20,620
F. Copies Not Distributed 1. Office use, left over, unaccounted, spoiled after printing	193	380
2. Return from News Agents	---	---
G. TOTAL *(Sum of E, F1 and 2—should equal net press run shown in A)*	20,979	21,000

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I'm a Doctor, and I'm Getting Tired

Irving Williams, MD

Author's Note: This article was originally written for the lay public.

I have been in private practice as a family physician and anesthesiologist for 30 years. I have cared for the elderly and the young, delivered my share of babies, and saved more than a few lives. I've lost sleep and shortened or missed vacations to provide consistent, quality care to my patients; and I have charged for my services fairly and provided care without question to those without financial means.

I have also spent 20 years working in organized medicine at the county, state, and national levels in an effort to allow my colleagues the ability to provide quality care to *their* patients. In those years I have watched with increasing concern the inroads made by regulators of all kinds which undermine those efforts.

The last decade of incredible medical advances has brought with it increasing criticism of those who use those advances to provide quality care to millions of patients. I agree that a way to provide care for *all* must be found. But the recent onslaught of political proposals to solve the ills of our "health system" has raised the level of criticism to new heights.

That is why I am getting tired. Not of physically caring for my patients, but:

- of the incessant bashing I take from the media;
- of being told physicians provide poor medical care;
- of reading that doctors are "rip-off artists" bilking insurance companies, Medicare, and Medicaid of millions of dollars;
- of hearing that I and my colleagues will not care for the poor, the uninsured, or HIV-positive patients;
- of being made to feel inferior by public figures whose own performance couldn't hold up to the scrutiny that I and all doctors must sustain;
- of being told I overcharge for expert care provided after years of training and experience;
- of having my profession over-regulated and blamed in part for the economic ills of a faltering economy;
- of watching politicians develop programs which will eventually lead to the demise of the finest medical system in the world;
- of being told that health care is excessively expensive, yet having demands placed upon me to provide the highest quality care possible;
- and, yes, of being told that neither I nor my hospital will be paid appropriately for those services after providing that necessary care.

In spite of all this criticism, I—and the majority of physicians—continue to try to provide the best care possible. The medical profession is one of the few professions which monitors itself in its performance. Medical professional associations demand continuing education as a requirement for membership. Not many other groups can honestly make that statement—certainly not the politicians and regulators who, if they had their way, would lead this country to medical mediocrity through restrictive and constricting laws and regulations...and certainly not the members of the media who seem to delight in the exercise of bashing the medical profession. It's time the doctor-bashing stop!

Many independent polls indicate that the individual patient is satisfied with his or her personal physician. We must be doing something right! Tens of thousands of physicians are out there doing the best they can in a hostile environment—providing excellent and, in many cases, free care to those in need. Before this country jumps on the bandwagon of some form of nationalized health care, it would do well to look closely at other government-operated systems. Do we really want a health system operated with the same standards and efficiency as the Postal Service, the Forest Service, or the IRS? I think not.

Let's begin to look carefully at the reasons for some of our health care delivery problems. Let's scrutinize the priorities of our people to see if health care is really a top priority, and if so, are they willing to pay for quality. And let's look at the funding provided. President Bush's "read my lips, no new taxes" may have been a slick campaign statement, but if implemented, it will lead inevitably to the reduction of both the quality and quantity of care provided by the medical profession. With fewer dollars we cannot provide increasingly sophisticated care to more people, many of whom live now longer with chronic illnesses.

Yes, I'm tired—as are thousands of physicians like me. Tired and discouraged. But we're still trying to do our best, even in the worst of circumstances.



Dr. Williams, a Lewisburg anesthesiologist and active member of the State Society, served on the Society's Board of Trustees for nine years and the Pennsylvania delegation to the AMA for 11 years.



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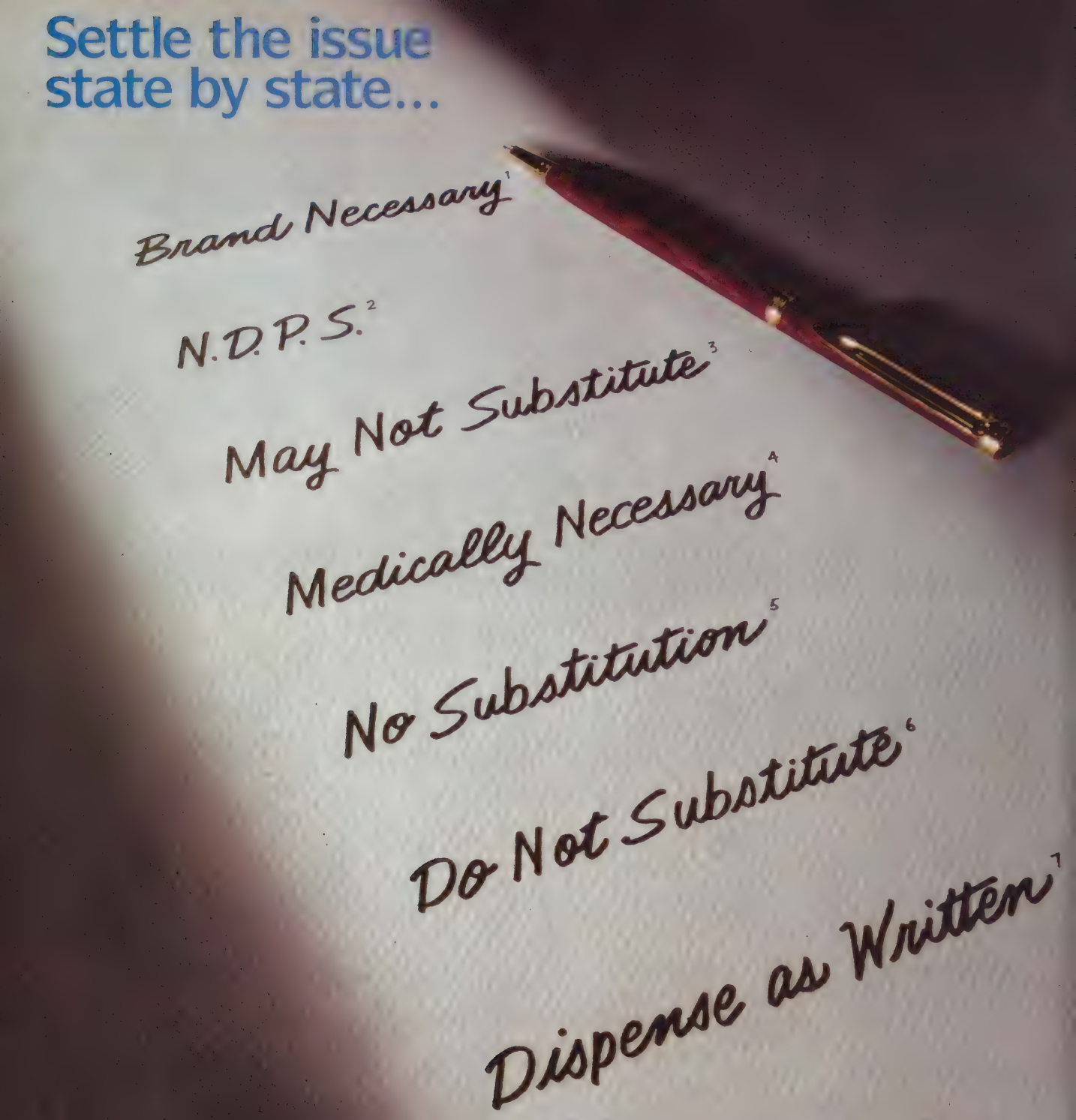
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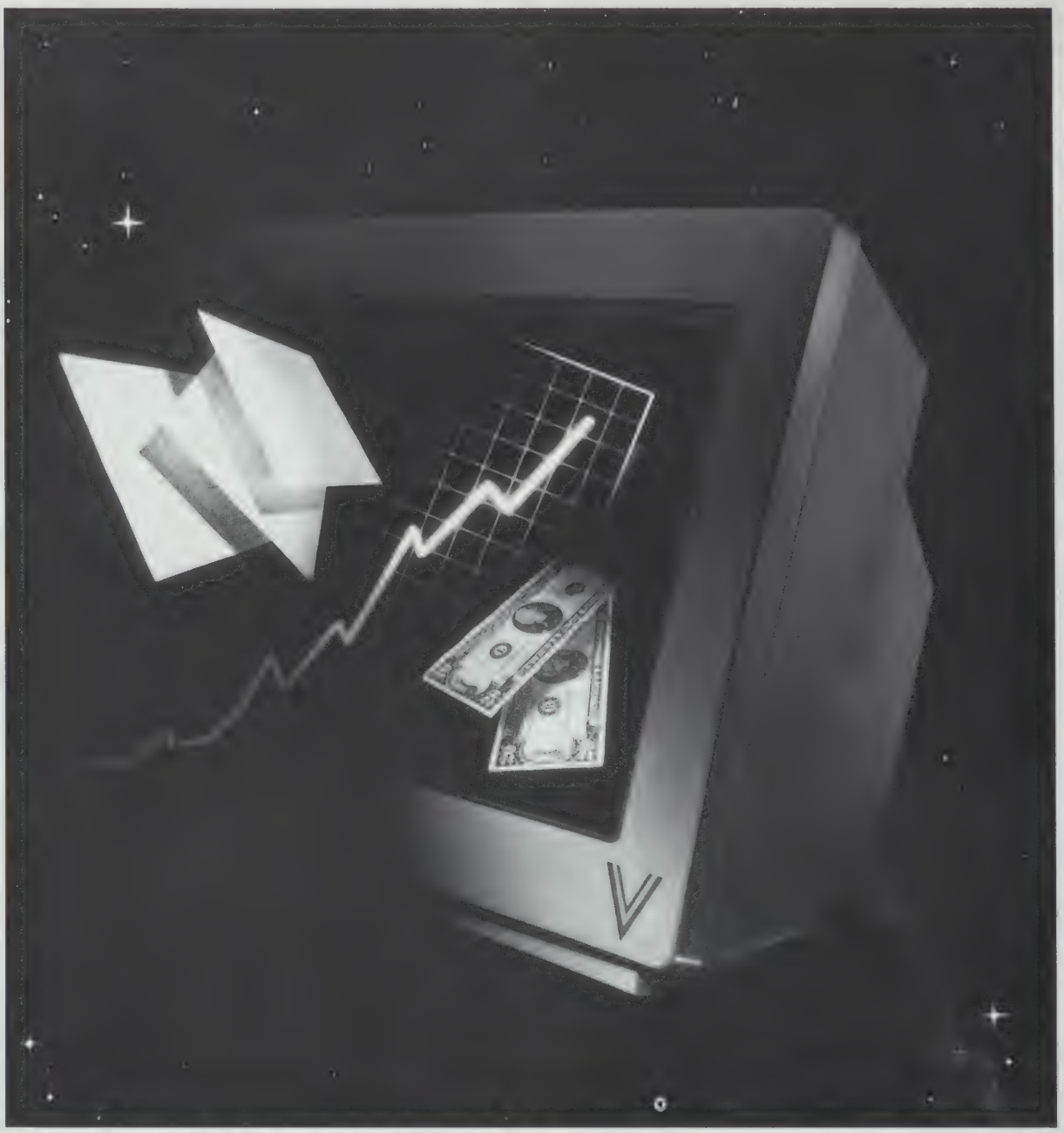
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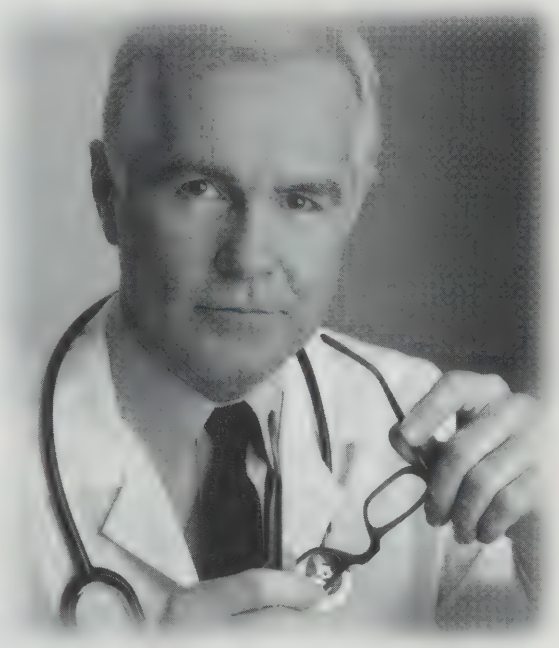
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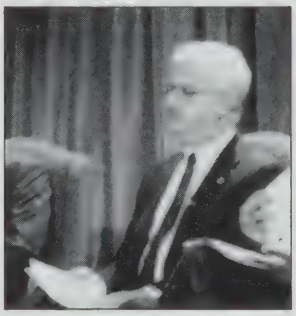
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Dr. Corlin

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Dr. Ferguson



Dr. Moyers

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24 Delegates Consider Socio-Economic Issues



At their annual October meeting, State Society delegates lent their support to the organization's primary public health and legislative directions. Coverage of the meeting and election results appear in *Newsfronts*.

Cover photo by Carl S. Socolow, Harrisburg

PENNSYLVANIA MEDICINE (ISSN 0031-4595) is published monthly by the Pennsylvania Medical Society, 777 East Park Drive, Harrisburg, PA 17111.
SUBSCRIPTIONS: $20 per year— United States and Canada; $30—all others. Single issues $3.00 per copy prepaid; special issues cost more.
POSTMASTER: Send address changes to PENNSYLVANIA MEDICINE, 777 East Park Drive, PO Box 8820, Harrisburg, PA 17105–8820. Second class postage paid at Harrisburg, PA 17105.

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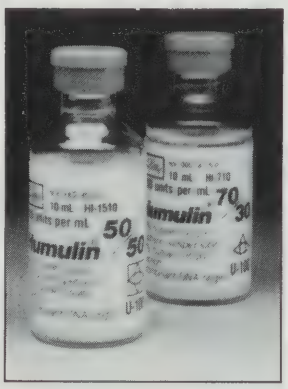
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GOVERNOR'S PARTNERSHIP PROPOSES "MANAGED COMPETITION": The governor's Economic Development Partnership has proposed a system of "managed competition" to provide health care to every Pennsylvanian. The governor says the plan, which will be reviewed in a series of public hearings in the next several months, would reduce costs through a system of competing managed care networks. The Society is reviewing the document and plans to participate in the public hearings.

HEALTH CARE REFORM PROPOSALS AVAILABLE: A draft of the Society's health care reform proposals discussing how to break down the barriers to care, how to get escalating costs back under control, funding models, etc., is now available for review. Though a summary of the draft will be published in January in this publication, members may request the full document by calling the Society's Division of Communications and Public Affairs at 1-800-228-7823.

GENERAL ASSEMBLY PASSES HEALTH CARE BILL: Both chambers of the General Assembly in late November passed an amended version of House Bill 20 on children's health care. The bill provides state-paid or subsidized insurance to children—some 40,000 eligible—whose families cannot afford coverage but are not poor enough to qualify for Medicaid. It also includes primary care and rural/urban programs. The section addressing referral networks and hospital medical staff obligations—which at one time contained mandatory physician participation—was deleted entirely from the bill, but may be reintroduced next year. At press time the governor was expected to sign the bill.

LEGISLATURE PASSES RE-ENACTMENT OF PHC4, CON: The legislature in late November passed Senate Bill 1975 to re-enact the Pennsylvania Health Care Cost Containment Council (PHC4). The bill appropriates $1 million for the 1992-93 fiscal year which will extend the PHC4 law until June 30, 1993. After that the law will "sunset" unless again re-enacted. Also, the legislature passed House Bill 1982 to re-establish the Certificate of Need (CON) program. The Society successfully pursued "due process" protection and substantive amendments, as well as provisions requiring proposal of a policy for licensure of different levels of ambulatory surgical facilities. Both bills have been sent to the governor for approval.

WORKERS' COMP BILL STALEMATES: After several months of work to reform Pennsylvania's workers' compensation system, the legislature adjourned without passage of such legislation. This allows the Insurance Department to move ahead with a 24 percent increase in related insurance rates. A complete review of this and other legislative issues will appear in the January 1993 issue of PENNSYLVANIA MEDICINE.

CABG REPORT RELEASED: PHC4 released on November 19 its report on coronary artery bypass graft (CABG) surgery. The Society maintains that the report should not be ignored, but should be used with caution as a basis for asking questions and obtaining more information. For background, see the June, July, and October issues of this publication and the December issue of *Executive Report*. Also, for a Society analysis of the report, call the Division of Communications and Public Affairs.

WELFARE CUTS TO BEGIN JANUARY 1: The governor's plan to cut Medical Assistance benefits for state recipients of General Assistance is slated to begin January 1, 1993. The plan will institute an 18-medical-visit-per-year limit and a coupon payment system. Physicians should be aware, according to officials, that if they treat a patient without first receiving a voucher, they cannot be guaranteed reimbursement for services.

SOCIETY, PBA SPONSORING FAMILY VIOLENCE PROGRAM: The Society has joined with the Pennsylvania Bar Association (PBA) to sponsor "Breaking the Cycle of Family Violence," a public awareness program to be aired on Pennsylvania public television stations in early January. A video, "Children of the Lie," stars Martin Sheen, and a studio panel will discuss the issue. Check your local listings for date and time. For more information, call the Division of Communications and Public Affairs.

PENNSYLVANIA MEDICINE
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P.O. Box 8820
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Random Thoughts After November 3

John W. Mills, MD
Medical Editor

It goes without saying that I was disappointed with the national election results. However, I'm glad it's over. With our modern communications we were "treated" to a saturating dose of political campaigning, unpalatable to many of us.

Historians tell us the presidential campaigns of the nineteenth century were much dirtier. Perhaps this editor is more sophisticated than our nineteenth century brethren, but I gather by the popularity of this election's "talk shows" that the average citizen literally eats this stuff up—we had 24-hour CNN coverage and all-night TV "ramblers" to do our thinking for us.

My analysis of this presidential election as it relates to our profession is fairly simple, therefore perhaps easily shot down. But then, it may provoke some letters.

"Choices have to be made—we can't do all for everybody."

In past editorials, I've alluded to the concept of behind-the-scenes staffers in the depths of Congress, who day-by-day, slowly as a cancer grows, push relentlessly toward enslaving the medical profession in this country—trying to reduce us to government employees, civil service category "X." I honestly believe this scenario.

My personal practice experience goes back only 32 years, but the first event I can pinpoint in this scenario is the Medicare legislation of 1964, under a Democratic president and Congress. Genuine concern for senior citizens and their health care culminated in that legislation. But many of us felt that the AMA let us down back then. In retrospect, I feel they only took the wrong tact—perhaps too late.

Since that time, we've come through evermore legislation, leading to the last few years' OBRAs [Omnibus Budget Reconciliation Acts]—each one more restrictive on medical practice. Then, in January of this year we received the resource based relative value system (RBRVS).

Ongoing problems with the peer review and 50 different state Medicaid laws, some of which are not even closely dovetailed to the federal Medicaid entitlements, have sunk us into a real quagmire.

RBRVS came with a Democratic Congress (Republican president), and most of the OBRAs were legislated in the same arena. Now our Democratic Congress, in railroad parlance, will have a "highball" or greenlight to continue their ways, blessed by the new Democratic presidency.

Jobs are first and health care second in President Elect Clinton's strategy. Both will consume money—lots of it. Where do we get the money? Taxes on wealthy Americans won't do it; more cuts in defense spending might help; but the bottom line will be higher taxes for *all*, and probably more national debt—already high enough to bankrupt us if we don't soon get a handle on it.

The American public really seems to think with their wallets instead of their intellects. It's time for them to seriously consider the indisputable fact that we can't afford all the medical care our profession is capable of delivering. Choices have to be made—we can't do all for everybody.

We're part of a world economy and global markets. We can be the greatest nation on earth, but our prosperity depends on the rest of the world—no longer can we isolate or insulate ourselves from what's happening anywhere on this globe or above it.

Elections usually do bring change. As we head for the changes of the twenty-first century, let us hope for the best, but let us not lose sight of our professional status. And let us implore and help the American people to recognize and deal seriously with the problems of access and cost while still maintaining everyone's freedoms.

Let's also declare all-out war on the four major social issues which sap the very life of this country: *HIV, illicit drugs, tobacco- and alcohol-related illness, and teenage pregnancy.* This is where our energy and resources need to be concentrated.

The AMA and your State Society are well-versed on health care issues. They will be at the table on both national and state levels as the debate continues. We must present a united front, for there are many players with self-serving agendas. Compromise will of necessity be the order of the day; we look to organized medicine to represent us with one voice.



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Of Politics, Health Care, and Change

Donald G. Ferguson, MD



This is being written immediately after the national and state elections, and in the light of victory for the Democratic Party on the national ticket. It also appears that, on the state level, little change will occur. What does this mean to us, to our practices, and to our patients?

First of all, it means little or no immediate change in the political climate in Harrisburg—for better or for worse. Second, the promise of change in the administration means obvious change in the federal attitude toward health care. Whether this change will be fast or slow, major or minor, is yet to be known, but it certainly means increased vigilance on our part to continue to protect the rights of our patients—and our special relationship with them.

The vigilance, and the timely notice of impending changes to our patients' welfare, and our own, depends on our organizations—the Pennsylvania Medical Society, our specialty organizations, and the American Medical Association. Guiding those changes depends on *us*. We as individuals will determine whether presidential and congressional action will be onerous or bearable, sweeping or gradual.

This is the political process in the United States. We who have elected our governing officials must now talk to them. We must tell them what they need to know about health care: about the importance of being able to care for our patients without burdensome regulation, without spending our time on paperwork instead of people, and about our own plan as physicians to care for the people of our state and of our nation.

Last month, the Society began circulating for comment copies of our current health care reform policy. This draft was put forth by our Committee on Long Range Assessment, and adopted by our Board of Trustees and our House of Delegates.

It is not the same document that we have seen in the past, nor is it the ultimate statement of our purpose as a profession or as a Society. However, it is a remarkable document, representing the fusion of quite a number of opinions, some of them quite diverse. The final version of this health care reform proposal will guide our policy into the future.

There was, and is, considerable sentiment to support a "pure" consumer choice model, along the lines of the plan developed by The Heritage Foundation. This continues to be our goal for the long run.

Meanwhile, there is at the state level much activity that may lead to more immediate action. Given the need for a timely, workable plan to present to the Pennsylvania legislature *now*, when it is poised to tackle the issue, we have developed a series of intermediate recommendations. These recommendations assume that the most prominent plans to appear in the state legislature during its next session will be based on employers serving as the foundation for health care funding. Our short-term plan uses an employer-based system, with strong consumer-choice features.

If the terms I have used in this column are unfamiliar to you, I commend to your study your Society's health care reform position paper. It contains background as well as our recommendations.

On the other hand, if you are one of the many physicians who have been following closely the health care reform debate, I urge you to pay special attention to this document of your own Society and ask you to support our proposal as it takes shape in legislation.

You may obtain an advance copy of the entire draft for your consideration and comments by calling the State Society's Division of Communications and Public Affairs at 1-800-228-7823. Also, a summary of the plan is slated for publication in the January 1993 issue of PENNSYLVANIA MEDICINE.



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LETTERS TO THE EDITOR

GROWING OLD AFFECTS UNDERSTANDING KEPRO

Somehow I thought it would never happen to me. Surely, I would never lose the ability to understand the process of decision making. I guess I was wrong. My understanding of this process has eroded as the result of growing old and out of touch with contemporary thought.

During my education, I was constantly challenged to answer two basic questions: "Why do you do what you do?" and "How do you know it works?" The answers to these questions were found by review of the literature and application of the scientific process—the process of recognizing a problem, forming a hypothesis, and validating that hypothesis. Apparently, this time-honored process is no longer in vogue at the Pennsylvania Medical Society.

In 1985, the Keystone Peer Review Organization (KePRO) was created as a subsidiary of the Pennsylvania Medical Society. The purpose of this bureaucracy was to ensure quality and appropriate utilization of health care in Pennsylvania—to protect the Medicare population from careless and incompetent practitioners, and to save our economy from greedy physicians. Seven years and $73 million later, have the goals of this organization been met? How does the KePRO experience stand up to the questions of scientific process that characterize my generation of physicians?

When KePRO is asked, "Why do you do what you do?" the answer is because the federal government mandates it. And when asked, "How do you know it works?" we learn that there is not one shred of evidence that seven years of KePRO review has improved the quality or utilization of health care in our commonwealth. In fact, a study to answer this question has never even been done! Seventy-three million dollars of taxpayer money has been allocated to a project with no measure of result. So much for accountability.

Well, I guess I just don't understand. But then, no one ever said growing old would be easy.

Philip D. Carey, MD
Carlisle

Editor's Note: This letter was forwarded to the president and administrators of the Keystone Peer Review Organization.

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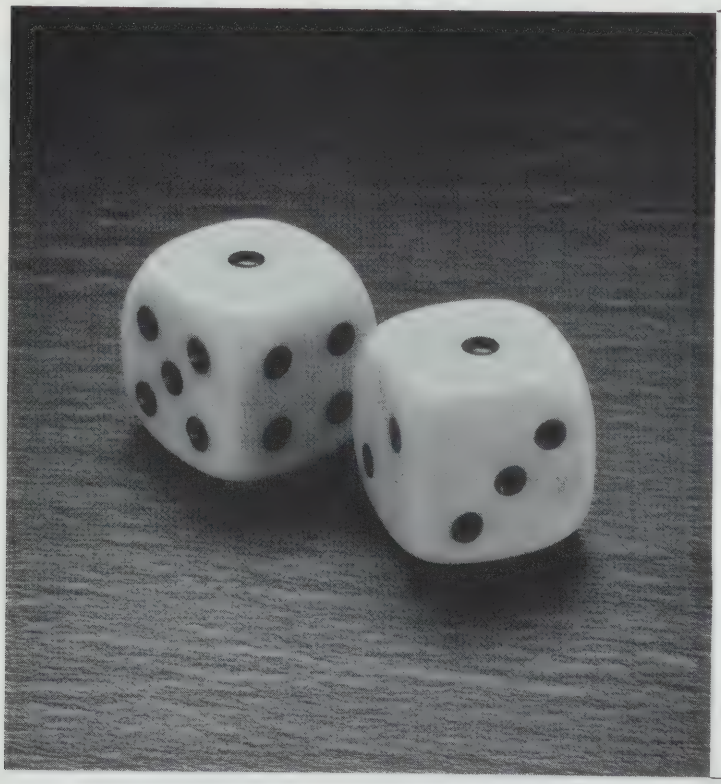
STATE PHYSICIANS "WELL SERVED"

I am writing to you to thank you for publishing the great practice management articles in PENNSYLVANIA MEDICINE. This afternoon as I was searching on a variety of computerized literature data bases for articles on personnel issues in physicians' private practice, I couldn't help but notice that all the best articles were in your journal. I finally decided to simply review the 800-some articles from PENNSYLVANIA MEDICINE, just in case I missed a few gems.

I couldn't help but think how well served the physicians of Pennsylvania were in having such a high-quality, state association journal. Unfortunately, when one routinely gets such a good publication, one might assume that this is the case from all state medical journals. From my vantage point, I'd like you to know that your journal is outstanding, especially in addressing some of the problems that physicians feel most vulnerable in—personnel issues in their private practices.

Keep up the good work!

Rya Ben-Shir, MLS, Manager,
Health Sciences Resource Center
MacNeal Hospital, Berwyn, Illinois



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Health Care Reform: California Reform Plan Blends Strengths

Richard Corlin, MD

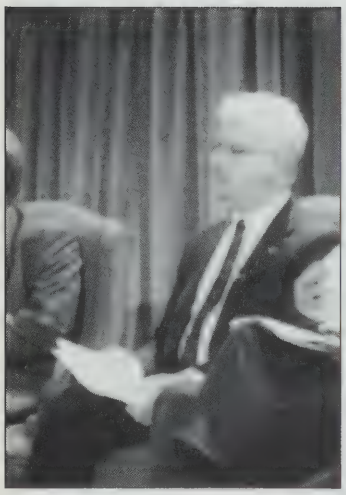
Dr. Corlin was part of a panel representing various sectors of the health care community at the Society's Forum on Health Care Reform, held October 23 in Philadelphia in conjunction with the Society's House of Delegates meeting. His remarks about the California Medical Association's health care reform plan are excerpted here. The California association's plan was, however, defeated in a ballot referendum.

Solving the problems of our health care delivery system is not going to happen in the first 100 days of the next administration, regardless of who is president. If the solution were easy, it would have been found a long time ago. What we need to do in the first 100 days of the next administration is be sure that we get the right start toward a solution that we get to as quickly as we can.

California is unique in certain ways; it's fairly typical in other ways. One [unique factor] is that by the end of this decade, we will not have the majority of any ethnic group in our population. We will be a state composed of several minority groups—some White, some Oriental, some Hispanic, some Black. This adds a tremendous diversity to our population, but brings with it certain health care and cost factors that we have to recognize.

Some fantastic work by Dr. David Battista at the UCLA School of Public Health showed enormous differences in the most effective way to provide health insurance to people in different ethnic groups. We've drawn upon some of that.

What follows is an outline entitled, "Principles of Health Care Reform." This is what the California Medical Association (CMA) went through as we decided that in a state like California—where we have six and a half million people without health insurance, and where we have had a cumulative state budget deficit of $25 billion in the past two years—that something had to be done *now*. We had waited long enough for health reform.



Dr. Corlin is speaker of the AMA House of Delegates and president of the California Medical Association.

Miller's Laws

Miller's Laws refers to some statements made by Dr. Stephen Miller, who, even though he was a physician, was a member of [Britain's] Parliament during the Labor Administration about 20 years ago. His position in Parliament corresponded to the position that Henry Waxman has in Congress.

[Miller] laid forth three principles for any government-run or government-mandated health care program. One, all decisions must be made at the most local level possible. Do not do central planning. I think our late experience with the HSAs [Health Services Administration] would confirm the validity of that. Secondly, physicians and hospital administrators with real experience treating patients and running hospitals must be involved in policy-making levels of the program. And thirdly, try not to make it a political football. Don't try to win or lose elections based upon health care. Recognize that we have got to work cooperatively to provide the best solution to the people.

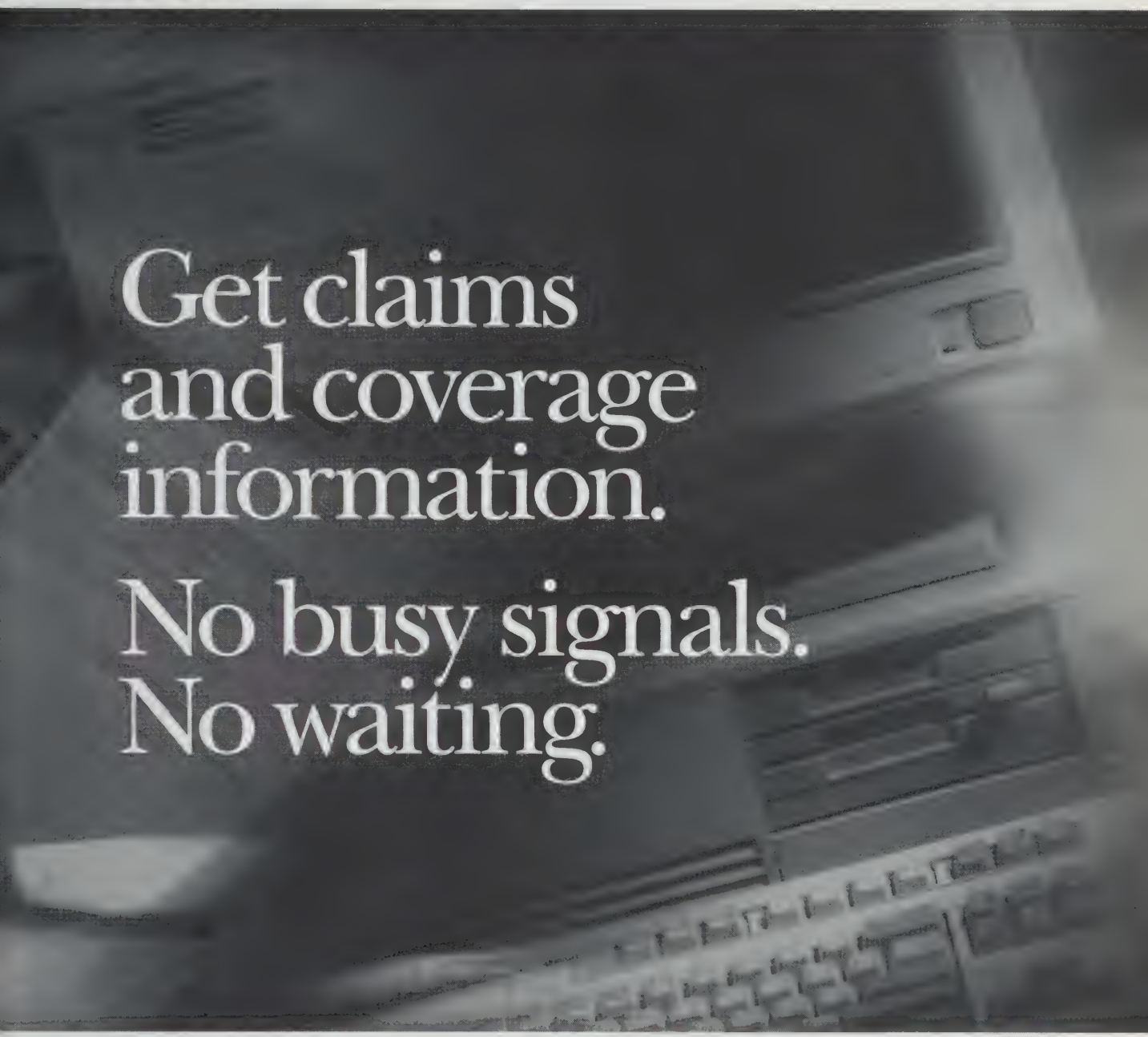
Basic philosophy

The basic philosophy is one of three philosophies. Volunteerism and negotiations, which is the way we have tried to provide health care for the past 40 years, has worked for 85 percent of our population; it hasn't worked for the other 15 percent. We have a real responsibility to guarantee everybody in this country access to the health care they need at the time that they need it. And the pure voluntary approach has not worked and increasingly will not work.

We, therefore, have two other alternatives: one, for the government to set rules under which the private sector has to operate; or two, for the government to run the system. For a variety of reasons, we strongly favor government setting rules under which the private sector continues to operate to deliver health care.

At this point I want to divert a little bit. I do not think it is defensible to say, "I don't want the government to run the health care in this country because I don't want the government to do it." It is defensible to say, "We have studied health care delivery in this country. We have studied

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the Hawaii system. We have studied the Canadian system. We have studied the Medicare and Medicaid programs. And we conclude that the government doesn't run the health care delivery system well in this country when they try to run it. Therefore, we don't want the government to run it." It's the same conclusion, but it's for a very different reason, and a reason I believe is defensible, as opposed to the ideology, which I believe is not defensible. Health care delivery is pragmatic; it's not ideologic.

Funding mechanisms

In terms of the funding mechanisms, again there are three items: honesty versus the "Unholy Trinity"; employer mandate *plus*; and tax based.

First is the issue of *honesty versus the "Unholy Trinity."* Honesty is to say, "While we need to get to universal coverage, we may not be able to afford to get there in one step. We may have to divide the problem into two steps—do what we can afford right now, and do what we can't afford now in the year or two down the road when we can afford it." It is much better to be honest than to claim to solve the whole problem now and deliver something that doesn't solve any of the problem.

The "Unholy Trinity" is the funding mechanism [of] how we got to Medicaid. And that is over-promise, under-fund, and shift the blame...we don't want to see it for everyone.

We strongly believe that an *employer mandate plus* is the funding mechanism that works. The *plus* is: we don't believe it is fair to saddle employers with the cost of providing health insurance for the unemployed uninsured. We think that should be a tax-based proposal funded out of general revenue tax, not a payroll tax.

And that's how we come down in California on dividing the problem into two steps. Seventy percent of the uninsured and 25 percent of the people on Medicaid are employees or dependents of employees. They can be covered now with an employer mandate system.

[For] the remaining 30 percent of the unemployed uninsured, we will come back with a second phase as quickly as we can—which has to be *tax based*—to provide health insurance for the unemployed uninsured. We reject a tax-based system in its entirety.

Insurance underwriting reform

In addition to the funding mechanism, insurance underwriting reform is crucial. We are finding out in California—and Governor Rockefeller mentioned that the Clinton people are aware—that the Health Insurance Association of America is the biggest enemy to health care reform in this country. They will fight as hard as they can to protect their profits, and their position is simply unconscionable. They are throwing into California $10 million in East Coast money to try to beat health care reform in California. When we tried to raise cigarette taxes, R.J. Reynolds threw $18 million into California, and we beat them, too.

Modified community rating is essential. The modification issue should still be allowed to rate for age. It makes no sense whatsoever, and indeed is counterproductive, to advocate a program where everybody in the same age group pays the same amount for health insurance. But we must not allow any exclusions for preexisting health conditions. We must not allow individual rating of one person's policy, or one small business's policy, depending upon the experience of that program.

We must, however, allow businesses to fold in the acute health care portion of workers' comp into the health insurance. That's a big cost-saving device.

Cost containment

• *Managed care*—Managed care, like it or not, is growing in this country. On the West Coast, it is the majority mode of care. We are not seeing new physicians go into fee-for-service private practice in any significant numbers at all. They are going into managed care private practices, usually in large multispecialty groups dealing with managed care contracts.

I'm not here to advocate it. I'm a reporter, not an editor. You may not like the news, but managed care is able to deliver health care, of a comparable quality in most cases, for less dollars per patient, and deliver it with greater efficiency; it's an effective cost-containment tool.

In reality, 95 percent of the insurance sold in the United States now uses one managed care technique or another—whether it's contracting of rates, utilization review, or whatever. But more organized systems of managed care are growing; as they become more common in Pennsylvania, taking a look at how physicians can effectively manage the managed care programs—not for our best interest but for our patients' best interest—is an essential item.

• *Basic benefits*—We need to see to it that we provide, in a universal mecha-

"You may not like the news, but managed care is able to deliver health care, of a comparable quality in most cases, for less dollars per patient, and deliver it with greater efficiency..."

nism, basic benefits and not unnecessary frills and whistles.

• *Fee review*—We need to petition the government, as the AMA is doing, to get back into the business of doing fee review. The federal Trade Commission forced us out of it several years ago.

• *Tort Reform*—Tort reform is absolutely essential. In California in 1975, when we passed our tort reform—which was a $250,000 cap on pain and suffering, collateral source rule, periodic payment of large awards, and a limit on contingency fees—we had the highest malpractice insurance rates in the country. We now have the twenty-seventh highest rate in the country. Obstetricians used to pay 50 percent *more* in California than in any other large state. They now pay 30 percent *less* in California than in any other large state. And doctors and hospitals don't pay malpractice insurance premiums, patients pay them.

You need only look at the Medicare system—which now has a specific reimbursement factor under RBRVS—and compare Los Angeles and Miami, and you'll find that the reimbursement factor in Los Angeles is half of what it is in Miami. Tort reform coupled with practice parameters, which will minimize defensive medicine, is an essential cost-containment device.

We're all aware of the statements that 25 percent of the tests and x-rays done are unnecessary. That comes from the speech that [Health and Human Services Secretary] Louis Sullivan gave in 1990. Nobody quotes his next sentence. I was there; I heard his speech. His next sentence was, "Many of these are ordered for defensive medicine purposes, and we need tort reform and practice parameters to eliminate the defensive medicine and put this cost-containment in place."

• *Cigarette tax and subsidy*—We now get to issue number five under cost containment, which is schizophrenia. I'm not a psychiatrist, but I define schizophrenia as any legislative body that complains about health care costs and subsidizes tobacco. The single most effective, simple, long-term cost-containment device in health care that we could pass in this country would be a $3-a-pack tax on cigarettes.

If you go to Montreal, or London, or Paris, or Düsseldorf, or anyplace else, and try to buy cigarettes, it's $5 a pack. And that's what it should be in this country.

• *Technology assessment*—Technology assessment panels to limit the inappropriate use of technology are also important.



More than 400 people attended the Forum on Health Care Reform held October 23 as part of the Society's annual business meeting in Philadelphia. Political insiders at the national and state level joined leaders of organized medicine for a frank discussion of the critical issues.

• *Anti-trust problems*—Correcting the antitrust problems that now prevent hospitals—even if they could get over their ego—from working together cooperatively in one town [is] important.

• *Manpower*—We have too many physicians in this country. We have far too many specialists. The fact that two-thirds of the residencies are specialty residencies is very counterproductive to cost-effective health care delivery. Managed care is exacerbating the physician surplus because it requires fewer physicians per thousand patients to deliver care. It is clear that for both physicians and lawyers, the normal laws of supply and demand do not work. A surplus of supply drives up the cost of care, and we need to recognize that and take action on it now.

• *Student debt and the NHSC*—Student debt is a major problem. The average student in 1990 graduated with $53,000 in debt. The average freshman medical student now will graduate with $70,000 in debt. The money to repay the debt drives up physician fee demands. We need to expand the National Health Service Corps (NHSC), provide extra physicians in medically underserved areas, and, in return for service in the NHSC, allow a conversion of medical school loans to scholarships. We solve three problems all at once.

• *Discussion of caps*—We now need to take a look at other items with regard to cost-containment; specifically, limiting how much money goes into health care—a discussion on caps. We believe very strongly that an artificial cap on "how much money we're going to spend on care, and no more" is a big mistake. It's a

Forum panelists included (see above photo, left to right):

Robert N. Moyers, MD, immediate past president of the Pennsylvania Medical Society, moderator

Robert A. Berenson, MD, faculty member, George Washington and Georgetown University Schools of Medicine, and member, President Elect Clinton's Health Advisory Group

Richard Corlin, MD, vice speaker, AMA House of Delegates, and president, California Medical Association

The Honorable Dwight Evans, chairman of the Appropriations Committee, Pennsylvania House of Representatives

George F. Grode, senior vice president, corporate affairs, Pennsylvania Blue Shield

Raymond Scalettar, MD, chairman, AMA Board of Trustees

Kenneth P. Yale, DDS, JD, Washington, DC, health care consultant with detailed knowledge of the Bush-Quayle health reform plan

The forum was sponsored by the State Society and the AMA.

mistake because it assumes that if you do that, the rest of the problems go away. They do not go away, and we need to correct the problems in the *system* of delivering health care.

We clearly have to budget effectively and, on an annualized basis, if we miss our budget targets, explain why, and make the necessary adjustments to understand it. But in approaching these limited amounts that we want to budget for health care, we need to recognize a few things.

Number one, the demographic changes in our population are enormously impacting our health care costs. If you take a look down the *important numbers* list below, $3,600 and $9,100 are two numbers that apply here—$3,600 is how much money it costs to provide health care for a 65-year-old; $9,100 is how much it costs to provide health care for an 85-year-old. And 85-year-olds are the most rapidly growing segment in our society right now.

We need to adjust our budgeted targets, not just for inflation and growth of population, but for growth in the population within each age group. We also need to recognize that we do not spend any money in this country on health care. We spend money for physicians' services, hospital services, pharmaceutical services, and so on, and we need to budget and adjust each one separately, and protect each one from caps on the others.

"I strongly urge the physicians to take the lead in this state in the health care reform debate."

CORLIN'S "IMPORTANT NUMBERS"

1 - $2.50

2 - $3,600 and $9,100

3 - $5 Billion

4 - $10 Billion

5 - $15 Billion

6 - $80 Billion

7 - $120 Billion

8 - 440,000

9 - 9%

10 - 24%, 48%, 15%, $3.50, $5.50, 38%

Long-term care

We decided not to include long-term care, for the simple reason that long-term care is not health care...never has been, and never will be. No country in the world includes nursing home costs in their health care budget. The single biggest reason why we spend a higher percentage of our Gross National Product on health care than Canada is that we include nursing home costs and they don't.

Nursing homes are essential; a program to fund them is essential. But it should be funded as a social service, separate from Medicare, not part of Medicare. The biggest risk to the integrity of the Medicare program is the fact that a nursing home benefit as part of Medicare will eat up all of the money available for the acute care of the elderly.

Important numbers

Finally, I want to go through the "important numbers"(at left), because I think they provide some perspective:

- $2.50 is how much medical cost is generated by each pack of cigarettes.
- $3,600 and $9,100 I've explained.
- $5 billion is malpractice insurance for doctors; $10 billion is malpractice insurance for hospitals; $15 billion is defensive medicine—so the tort system causes $30 billion of our medical care costs.
- $80 billion is the total amount of money that all the doctors in the country made last year; and $120 billion is the amount of money we spent last year on tobacco-related illnesses. That puts things into a little perspective.
- 440,000 is the number of people who died from cigarettes last year.
- Nine percent is the percent of the health care dollar that winds up in the doctor's pocket. That nine percent is on the table for discussion when we talk about limiting health care expenses and reducing them. But you don't correct the problems in a system that costs too much by concentrating on nine percent and ignoring the 91 percent. We are willing to put our nine percent on the table, but the other 91 has got to be there also.

The last line of numbers are the Canadian system. It's been the CMA's advocacy of our Affordable Basic Care proposal that has totally eclipsed any discussion in [California] of the Canadian-type system. The advocates of the Canadian system are now regarded as a fringe nuisance.

One of the enormous benefits of our proposal is all the discussion on health care reform in California is centered around the CMA proposal.

To explain number 10:

- 24 percent is the percent of [American] earned wages that are paid in income taxes—state and federal combined, all taxpayers averaged; 48 percent is what that number is in Canada.
- 15 percent is the sales tax in Quebec.
- $3.50 is a gallon of gas in Canada; $5.50 is a pack of cigarettes.
- 38 percent is the amount of the health care dollar in Canada that goes for health care—and in Canada, you cannot deduct mortgage interest from your taxes.

If you want a single-payor, government-run system—fine, put this tax structure in place to pay for it.

Conclusion

Going through this exercise has led us to the conclusion in California that an employer-mandate, insurance underwriting reform, workers' comp reform, and cost containment package is the essential component.

I strongly urge the physicians to take the lead in this state in the health care reform debate.

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Address of the President: Getting Involved

Donald G. Ferguson, MD

This is an excerpt from Dr. Ferguson's inaugural address presented on October 24 to the Society's House of Delegates at its annual meeting.

I have been asked what the theme of this year of service to you in the Pennsylvania Medical Society will be, what I want to accomplish, and what my priorities will be. Yesterday morning, I spoke to this House of Delegates about what I thought *ought to be* some new directions and renewed emphasis on existing priorities of this Society (see "Recommendations of Dr. Ferfuson," next page). But...I am here to represent you, the 21,000 physician members of the Pennsylvania Medical Society, and above all, the interests of the patients whom we all serve.

"The words, 'my doctor'—that's what keeps us going."

We are, above all, advocates for our patients, and we must continue to place our patients' welfare above our own, as we have throughout our long history as a profession.

Ours is an honored profession; and as long as we keep our patients' welfare above our own, it will continue to be so. But to continue to be effective advocates for our patients, we must be increasingly willing to step out of the office and out of the hospital, and into the public's view.

When we prescribe a medication or recommend a procedure, we are doing our best to improve our patient's health and well-being. At the same time, those in government are making decisions about what kind of medication we can prescribe and whether we can recommend certain procedures at all. Clearly, our care for our patients cannot and *must not* stop in the examining room. We *must* speak out and protect our patients *wherever* their welfare is threatened.



Dr. Ferguson is the Society's 143rd president.

I don't want to be a vendor or a provider or an employee. *I am a doctor. That's what I started out to be. That's what we all started out to be.* We are all here because at some moment in the past, we knew we wanted to be *doctors*. And we wanted it more than anything else. We worked and studied for it, and we, and our wives, and our husbands, and our family and friends sacrificed time, resources, pleasure, and leisure!

Don't give it up—that professionalism that distinguishes us from others!

You physicians who are here are the elite of medicine. Not necessarily because you are distinguished scientists or teachers of medicine, but because you are here, working for your profession, when you could be doing so many other things with your time. Still, there are many, many more of our colleagues who *aren't* here. They are back home, doing the job that we are all about—*taking care of patients*. They—and we—and many other dedicated health care professionals are in what I call the front lines of medicine: doing our job; keeping our communities together; working with neighbors, friends, and all of society to help each other.

I promise you the best that I can give during the coming year. It's little enough return for what you have given me—the pride that I have seen in hundreds of you, working hard and selflessly for our profession. *Our patients,* not ourselves, are—and must be—the reason we exist as physicians. *We* are special, as long as we keep *them* special—as long as we keep the word *"doctor"* one that *they* keep special. *"My doctor"*—that's what keeps us going. Walking into a home or an office or a hospital and *seeing* that patient light up—in hearing those words—"That's *my doctor.*"

That's what I want to communicate to you here, to all those of our profession whom Anne [Mrs. Ferguson] and I will visit in the coming year, and to those in our community and in our state *who need to know our purpose.* I want to communicate that pride in our profession, that sense of the nobility of our calling, and my deeply held belief and conviction that a doctor is more than a person, more than just another technician in an increasingly technological society. And certainly more than the vendor, provider, or employee that some would have us be.

We are doctors! Ours is a calling, not a

trade! It's a special way of life and a ministry that has been honored by a special place in society through many years, indeed through most of recorded history. It is *ours*—it has been handed to us with honor by generations of dedicated, selfless practitioners of an art that is *more* than just technical competence and scientific knowledge. It is the *understanding* of our patients that makes us special. It is placing *our patients* at the center of our concern, and their welfare at the center of our lives, that earns our place in society—and sometimes the annoyance of our wives, husbands, and families.

It isn't the money, the social prestige, or the country club or athletic club that brings us out at two o'clock in the morning, any more than it's the money or the prestige that brings the minister, the priest, or the rabbi out at the same hours, essentially on the same errand. We're there because that's what we *do*, and that's what we *are*...that's what being a doctor is all about.

We make a living—a secure living, a *good* living by most people's standards. We have a position in our communities which is secure, honored, and recognized beyond most people's attainment. Yet, most of us are not rich, even by the standards of our communities. Many of us are as worried as our neighbors about the erosion of our savings, the increasing costs of educating our children, and of maintaining a practice.

We have to work harder and longer to maintain good patient service while spending more and more of our productive hours producing paper, working on forms, and meeting regulatory and coding requirements, instead of spending that time doing what most of us really want to do—what we are all about, as a profession—*taking care of people.*

When I was a child, I had a very comforting fantasy. I had a rich uncle. I didn't quite know who he was, but I knew he existed. I would hear little snippets of conversation among cousins and other family members about our rich uncle...It's a fantasy that I could wish for all of us, because it helped make my life and my future secure. Someday the rich uncle—who liked me, I was sure of that—would pass on to his reward and shower me with gold, so I would be secure for the rest of my life. This was during the 1930s, when most of us were far from secure about the present—or the future. Sound familiar?

Anyway, one of the disillusionments of growing up was finding out who this rich uncle was. He was real, but he was my father. He was a doctor—a family practitioner, later turned radiologist—who made a living, the kind of living that many of us still make, but we weren't rich. We got along on very little by today's standards. When he got paid, which was always problematical, the payment was often in barter or farm produce. As a family, we made do with what we had and tried to save for the future. Yet, to our neighbors and my cousins, we were the rich people on the block.

The "Doc" had a security that few had. He had a steady job. We were eating—the barter took care of that. And we had our home and the assurance that we would stay there as long as we wished. *That* was riches, and it still is—a calling which gives us security and the respect of our neighbors.

There is one particular doctor in this room, with whom I am proud to be associated. He has a family practice, and has had it throughout his career. It used to be a comfortable practice in a "good" suburb of Pittsburgh. It's now in an inner-city area that reminds me of the place where I grew up in the 1930s.

During the worst of the riots that followed the assassination of Dr. Martin Luther King Jr., when many of our inner-city neighborhoods were in turmoil and some in flames, this doctor's neighbors came to him and said, "We *want* you here. You're good for our neighborhood, and we *need* you here."

So while other neighborhoods were burning, his was cool. And so was his office. It was guarded by his neighbors. It was protected by his community, because it was needed there. All of us are needed, from the university researcher and specialist, to the rural and inner-city physician. We're needed, and we'll be there—if they will let us.

We're asking, working, and when necessary, battling to be allowed to do our job. It's sad that we sometimes have to battle with regulators and public officials who have the same job that we do—to take care of the people.

We in the Pennsylvania Medical Society are trying to help. We're doing our job: we, here in this room, by being here; your colleagues back home by taking care of the patients while we're away.

But, to keep doing our job, we need you to help. *Get involved!* Get your colleagues involved. Get your families and your friends and your patients involved. Tell the legislators and the regulators how we're being hassled and drowned in overregulation. Tell them, and work with them, and let us get on with our work.

Recommendations of Dr. Ferguson

The following recommendations were made by Donald G. Ferguson, MD, in his Address of the President Elect, presented to the Society's House of Delegates just prior to his inauguration as the Society's 143rd president:

- I recommend that this House of Delegates work with the entire Society to strengthen our legislative program by increasing membership in our Legislative Action Teams, by increasing support of our state Political Action Committee, and—together with the American Medical Association and their political action committee—by building on Pennsylvania's current participation in our federal efforts.
- I recommend that the Society continue to support the work of the Joint Pennsylvania Medical Society-Pennsylvania Bar Association Task Force and consider appropriate ways to expand this cooperation into other areas of family violence and neglect.
- I recommend that the Pennsylvania Medical Society search out opportunities to form alliances, political and otherwise, to continue the Society's work of advocating for the health and well-being of the people of Pennsylvania.

Address of the Past President: Reaching Out

Robert N. Moyers, MD

This is an excerpt from Dr. Moyers' exaugural address presented on October 23 to the Society's House of Delegates at its annual meeting.

During this past year, I have traveled well over 50,000 miles throughout Pennsylvania and our neighboring states. I have been impressed by one overwhelming observation: we colleagues belong to a great, caring profession. And I'm proud to be a part of it.

Everywhere I went, I found a warm hospitality that, frankly, I didn't expect. I was prepared to be shot at with sharp-pointed arrows labeled unification, RBRVS, and so on. But instead, I found genuine concern as to where we all are headed over the next few years.

I've had the opportunity to meet with thousands of fellow citizens, including colleagues, senior citizens, and key leaders from business, labor, and government at all levels. Also, you may remember from my talk last year that one of my goals for this year was to meet with as many hospital medical staffs as possible. The purpose was:

- to reach non-member colleagues as well as our own Society members;
- to help them to realize that there are better ways to deal with the onerous demands of government and others, rather than just by griping among ourselves; and
- to tell them that if we value our professionalism, and if we value the basic freedom to care for our patients as we have been educated to do so, then we must work together.

We must build our professional strength, and we must use our God-given intelligence to master the political process. To do any less is unacceptable, nonproductive, and—I am convinced—not in the best interests of our patients or our profession. I think we have made a beginning in this special outreach, but more personal effort is needed to attract and involve more of our colleagues throughout the state. I'm happy that Don Ferguson, [the Society's newly inaugurated president], plans to continue with and improve these outreach efforts.



Dr. Moyers is immediate past president of the Society.

As far as our organization is concerned, I am pleased to tell you that in my opinion the health of the Pennsylvania Medical Society is very sound. Ninety-one percent of those surveyed in our latest membership survey expressed satisfaction with our activities and our services. We, however, will not rest with that percentage of approval, but will continue to devote energies in strengthening the Society to deal with the challenges ahead.

As I have said, your Society is sound. We are reaching out to the growing areas of our physician constituency, but they are not growing as quickly as they should be. So far, we have focused on women physicians and graduates of international medical schools. We still have to work to involve physicians from diverse racial and ethnic backgrounds as well.

We in leadership and on the Board do all that we can to be responsive to the needs of our grassroots physicians. And we certainly do our best to represent the interests of *all* of the physicians of Pennsylvania. However, I must say to you that this is not enough. Too many of our colleagues are not members of our Society, [and] too few of our members are devoting enough time and energy to meet the important objectives in legislation, public health, and our practice issues.

Our physician constituency is changing rapidly, and the Society must also change if we are to be relevant to our members and to attract new members. It should be self-evident that our political strength is directly related to increased membership. *Therefore, I recommend that the Society create a task force to identify in detail the makeup of the Society's changing constituency, the needs of that constituency, and meaningful ways to meet those needs.*

I recommend that this group include participation from young physicians, medical school faculty, women physicians, graduates of international medical schools, physicians in group practice as well as in private practice and managed care, and finally, members and non-members. I further recommend that the members be appointed jointly by the president, chairman of the Board, and speaker of the House of Delegates.

And finally, I recommend that this group be charged with reporting its findings and recommendations to the House in 1993. In the meantime, I would strongly urge that the task force begin immediately to initiate grassroots involvement in Society activities.

I want to emphasize that my concern here is to find new ways of reaching physicians and involving far greater numbers in active participation in this Society. Outreach is *very* high on my list of concerns...our organizational effectiveness depends on a strong, active membership.

In recognizing the changing needs of membership, we recognize the need to develop new products and services, [and] we also need to focus on generating more non-dues income to diversify and strengthen our base.

In order to achieve both of these objectives, *I recommend that the Society embark upon a feasibility study to determine whether we should create a for-profit subsidiary to provide physician services and some other projects that will create new sources of revenue.* Other societies around the country have been very successful in these ventures, and our Society should be given the opportunity to derive similar benefits.

My third recommendation has to do with our Society's relationship with Pennsylvania's medical schools. As a result of our meeting with representatives of the six medical schools in Philadelphia, there was agreement that we [the medical schools and the State Society] would both gain much from a cooperative relationship on legislative issues. *Therefore, I recommend the creation of a task force with representatives from the Society and Pennsylvania's medical schools to explore and recommend collaborative activities that would be mutually beneficial.*

My fourth and final recommendation has to do with what I believe will be a major factor affecting our ability to care for patients in the future: managed care.

We recognize that the Society has already initiated efforts in this area, [but] *I recommend that the Society take a strong and active role in studying the implications of managed care.* I further recommend that we develop clear and definite recommendations for our members about how to deal with managed care programs.

I also believe that we must carefully evaluate the option of a statewide IPA [independent practice association] or other managed care activity. The Pennsylvania Medical Society must create for physicians a base of support and bargaining strength, and we do not have it now as individuals.

Now let me review for you some of our accomplishments over the past year. We have strengthened our legislative efforts across the board. In addition, we have developed better communications with the various players in the public arena—the AARP [American Association for Retired Persons], the Chamber of Business and Industry, various legislators, and even the state administration.

We have moved from an adversarial approach to one of developing working relationships to solve problems. This collaborative approach requires a pragmatic attitude. We can't always expect to be winners. When we sincerely work to solve problems, sometimes we have to give—as well as expect the other side to give at times. However, we do recognize that acceptable compromises are not always possible. And when it is not in our best interest, then we must draw the line, roll up our sleeves, and get tough.

I believe your Society has never been stronger or better prepared to meet the future than it is now. Physicians have never had a better opportunity to make a difference in the way things work. This is a time of change, and change can equal opportunity. But if we are to succeed, we must further strengthen our organization with greater numbers and more active involvement.

In this political environment, our perspective is critical in bringing the needs and concerns of our patients to the forefront. Many in health care reform say that they are speaking for patients, but only physicians know first hand what is involved in caring for patients' needs; only physicians know the full impact of governmental policies on our ability to provide quality care. We must be advocates for our patients.

I ask you to reach out to your colleagues who are not members, and also those who have not been active members, and encourage them to join us at this crucial time, this turning point in the health care system. I cannot state it strongly enough: unity is strength.

If we are to accomplish our goals, we must build our professionalism. And we must use our inherent abilities to master the ever-changing political climate. I am confident that Dr. Ferguson [as president], working with you as leaders, will provide the leadership and the successes that I know are possible.

It is time we change frustration into confidence and optimism. Our patients are counting on us.

"I cannot state it strongly enough: unity is strength."

Society to Recognize Physicians Involved in Their Communities

Richard T. Bell, MD

The Society's 1992 House of Delegates established the Physician Volunteer of the Year Award to recognize volunteer efforts of Society members. This editorial offers statistics on volunteer efforts nationwide, focuses on the importance and benefits of such efforts, and provides suggestions for physicians in getting started.

"The medical profession needs to project a more favorable public image."

Volunteering has been an American tradition since the colonial era when there was a need to help others for the common good and self survival. It fosters social bonding, which is seen in such diverse activities as Amish barn-raisings, volunteer fire companies, or the patriotic act of protecting the community during war.

Unfortunately, the spirit of activism and involvement of the 1960s gave way to a period of increased individualism. Ayn Rand's *Atlas Shrugged* spawned the conservative objective movement, which is blamed for inspiring the "greed is good" ethic adopted by the "me" generation. This relatively self-centered lifestyle produced a diminished community commitment because of a pervasive "What's in it for me?" credo. A concurrent philosophy of some politicians and economic advisors advocated that money came first and humanity, a distant second.

Since the Great Depression, there is a tendency to expect government to provide large-scale social services which now are taken for granted. However, when people complain about cutbacks or increased costs of these governmental services, they fail to consider what the economic situation would be if volunteers did not give their time to nonprofit organizations. Volunteerism decreases operating costs while maintaining or increasing delivery of human services. The value of volunteer services performed in 1990 alone is estimated to be worth billions of dollars.

Unfortunately, government-funded social programs are not enough, since one cannot hire educated Good Samaritans. Although money is important, nonprofit organizations cannot survive solely on financial support. They need people to implement their programs.

In the past, many Americans believed they had performed their civic duty solely through a financial contribution. But now they are increasingly committing their time as well. Volunteerism has increased to where the nonprofits have become America's largest "employer."

In 1987, 45 percent of the adult population volunteered. By 1990, 90 million Americans, or 54 percent of adults, worked an average of three hours a week for nonprofits. Experts project that within the next 10 years, 120 million or two-thirds of American adults will volunteer an average of five hours per week. This represents a doubling of the manpower availability for nonprofits over the next decade.

Recent data revealed that 56 percent of Americans over 30 years old volunteer, while only 37 percent under the age of 30 do so. It appears that after the age of 30, as many settle into a career and family, people are available to give their time and energies to nonprofits.

Because physicians have been criticized for not getting involved in their community, medical societies are perceived as self-serving organizations that represent people who take more from their community than they give. Although this is another unfounded stereotype, it can be dispelled by Pennsylvania Medical Society members. The medical profession needs to project a more favorable public profile. With the challenge of increasing governmental involvement in medicine, physicians must solicit and win community support in order to maintain quality health care (see "Focus on Physician Volunteers," next page).

State Society physicians who volunteer their time in community activities not only lend credibility to the Society, but also enhance the profession's image by

Dr. Bell, a practicing physician in the Reading area, is the pulmonary representative to the Society's Specialty Section.

gaining the respect of business and community leaders. Human service agencies may be reluctant to approach physicians because we are perceived as being too busy. In fact, physicians are probably no busier than other business executives who find time to volunteer. To facilitate community participation, county medical societies can establish volunteer placement programs for nonprofit organizations to recruit interested physicians.

Some physicians believe they already perform volunteer work by caring for welfare and indigent patients. However, other businesses incur bad debts for their goods and services, but still donate their resources to nonprofit agencies. Nothing is perfect in the real world, but human needs still remain perfectly real.

Physicians learn to be leaders through professional education. Although special training is usually not required to perform volunteer work, any that is necessary will be provided. Service organizations are delighted to work with intelligent, creative people who infuse fresh ideas. Volunteer even if it is just on a limited basis. You don't need to give a great deal of time unless you wish; any effort is appreciated.

Community service is said to be a form of enlightened self-interest. Psychologists believe that the need to be of service to others is as great as the basic needs for food and shelter. In fact, many physicians entered medicine to fulfill a desire to help others. One may find that helping others without the pressure of politics, competition, or people expecting miracles can be fun and relaxing. As a volunteer, you might even learn new skills and meet interesting people. The demands need not be great, most volunteer organizations are flexible.

Some volunteers no longer consider their work as charity but as a career parallel to their paid jobs. As they expect in their regular jobs, they wish to be trained, to be held accountable for performance, and to have opportunities for advancement to unpaid managerial positions in the nonprofits. Thus, volunteer work becomes a measure of achievement and effectiveness while providing self-fulfillment and meaningful citizenship.

Realizing the importance of volunteerism, the Society's 1992 House of Delegates established the Physician Volunteer of the Year Award. An excellent way of generating nominations is to establish similar physician volunteer awards at the county level.

Society recognition of members who have performed exemplary volunteer community service should not be viewed as unprofessional public boasting. It is honoring people who have made important contributions to their community and who just happen to be physicians. Since the motivation for most volunteers is not for glory, it is quite fitting to thank them for their faceless, quiet efforts. Such recognition is more appreciated and significant coming from one's peers.

Small improvements build the base on which larger goals are met. As physicians, we know that one can overcome many obstacles and still achieve a meaningful goal.

Make a commitment to an organization in which you believe. There are ample opportunities to provide non-monetary help for political campaigns, religious groups, the Chamber of Commerce, or other worthwhile organizations. You can show appreciation for the undergraduate or medical college which gave you access to your profession by getting involved in alumni activities.

By volunteering before you are asked, you make the system work. But don't just become a passive member of a nonprofit organization—participate. Your input, whether in the planning or implementation process, will enhance the group as you achieve the self-satisfaction that comes from contributing to a worthwhile organization. As a volunteer, you may ultimately make your community a better place in which to live, and that's good for you, your family, and everyone!

Focus on Physician Volunteers

Beginning with the January 1993 issue, PENNSYLVANIA MEDICINE will feature a series of interviews with physicians involved in community public health initiatives. If you or a colleague play a role in such activities and would agree to an interview, contact The Educational and Scientific Trust, or this publication.

"Realizing the importance of volunteerism, the Society's 1992 House of Delegates established the Physician Volunteer of the Year Award."

Delegates Consider Socio-Economic Issues

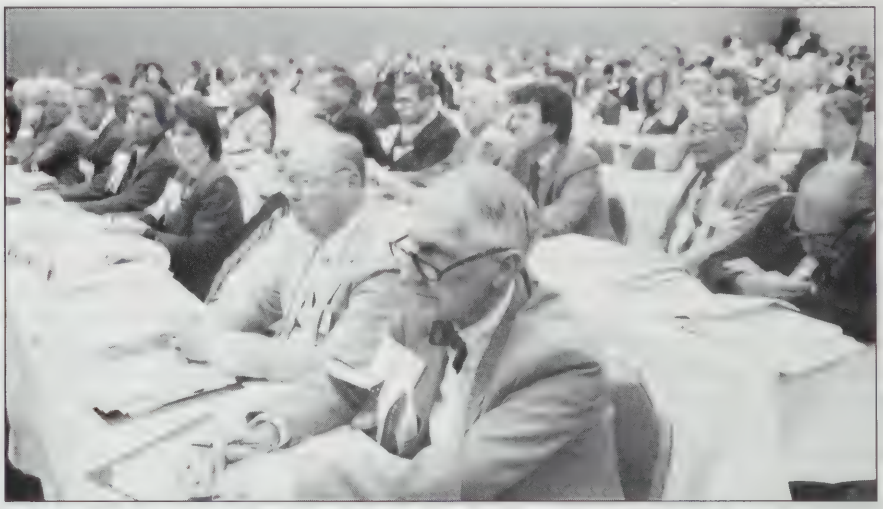
Maria T. Montesano
Assistant Managing Editor

At their annual October meeting, the Pennsylvania Medical Society's 254 delegates lent their support to the organization's primary public health and legislative directions. At issue were such complex socio-economic topics as defining health care prioritization, developing a viable health care reform stance, and evaluating HIV/AIDS confidentiality policies.

Delegates also wrestled with public health dilemmas, such as the resurgence of tuberculosis, concerns about hazardous waste incineration, and family violence. And they asserted the Society's goals in internal restructuring and in defending organized medicine: a thirteenth trustee district was added and efforts to aid the financial crisis in the state's medical schools were offered.

Prior to voting, delegates attend a series of hearings of the Society's seven reference committees, where advocates and opponents of each report and resolution air their views. This year the delegates adopted 63 reports and resolutions; the remainder were either referred for further study, not adopted, or filed.

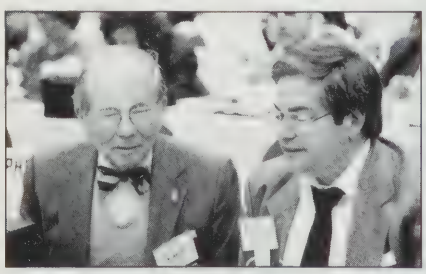
Full proceedings of the annual meeting will be published in the January 1993 issue of PENNSYLVANIA MEDICINE.



Delegates at the Society's 1992 annual business meeting considered 138 resolutions and reports on such issues as health care prioritization, health care reform, HIV/AIDS confidentiality, tort reform, and workers' compensation reform. A total of 63 resolutions and reports were adopted. (For a complete overview of actions, see page 28.)

Redistricting decided

For several years, the delegates have debated options for rearranging the Society's trustee districts to more fairly distribute urban and rural representation. This year they considered three proposals and voted to add a thirteenth district, Allegheny County.



David M. Sklaroff, MD (left), and Robert B. Sklaroff, MD, father and son, were among the 44 delegates representing Philadelphia at this year's annual meeting.

Proponents of the adopted plan explained that in past years, Allegheny County, as part of the Society's Tenth District, overshadowed Beaver, Lawrence, and Westmoreland counties, also in that district. The delegates agreed that the number of members residing in Allegheny County supported the formation of the new district. Carol E. Rose, MD, of Pittsburgh, was elected to serve as the first thirteenth district trustee.

The other proposals recommended: 1) redistricting the state into six trustee districts of approximately 3,000 members each; and 2) distributing membership into 10 trustee districts, more equitably divided. Though the first proposal received little support at the reference committee, the committee did feel the second proposal showed some merit. The Society will continue to explore the issue.

Medical school financial woes

The delegates adopted several resolutions that seek to address the problems of cuts in state funding to medical schools, tax deductibility of educational loan interest, and loan repayment.

The Society will urge the governor and legislature to restore full funding for Pennsylvania's medical schools. All funding for non-state-related medical schools was cut from the 1992-93 state budget, and funding for state-related universities was cut by 7 percent in the past two years.

Members who spoke at the reference committee outlined the problems facing state medical schools in light of the governor's cuts and suggested that organized medicine and academia must speak with one voice on this issue since these cuts ultimately affect health care in Pennsylvania. Representatives of Pennsylvania's medical schools, who met with leaders of the Society in conjunction with the annual meeting, agreed that such an effort would be worthwhile.

To further aid medical students, the Society will urge the American Medical Association to encourage legislation to restore the tax deductibility of educational loan interest for primary care providers. Resolution 92-2 noted such action should be considered because of the rising costs of medical education,

the substantial debts of young physicians, the declining number of physicians entering the primary care field, and the proliferation of managed care programs which rely heavily on primary care practitioners.

Passage of such legislation may be difficult, some physicians said, but others told the reference committee they strongly support such efforts. At the House, a move to refer the action to the Board for further study was defeated, and in the end the resolution was adopted.

Also, the House adopted Resolution 92-42, which calls for the Society to support legislation to ensure that residents-in-training and others in post-graduate medical education will continue to have the option of deferment and forbearance of repayment of student loans throughout their training and for an additional three years in the event of hardship. The reference committee heard overwhelming testimony in support of the resolution.

Prioritization of health care

Prioritization of health care has been an on-going concern for the Society since the 1990 annual meeting. This year, the delegates adopted a board-recommended policy statement which reflects the belief that physicians should be involved in the prioritization of health care.

The statement also draws a clear distinction between "prioritization" and "rationing" of care. Prioritization of health care is defined as "a process that rank orders medical services, categories, and/or treatment options on the basis of value." Rationing is defined as "a process that restricts the application of resources to those medical services, categories of services, and/or treatment options ranked higher on a priority list and denies access to others by, in effect, drawing a line."

Supporters of the board recommendation argued that there are not enough resources to pay for all the medical care that society demands and that physicians must become involved in the prioritization process rather than letting government set priorities. Opponents, however, claimed that prioritization *is* rationing, which would be inherently unfair to the poor and minorities and would project a negative image of the State Society.

After hearing testimony, the reference committee recommended adoption, stating that it "believes that the policy statement is relatively general in nature and could serve as a useful guide for the Society as the health care reform debate evolves."



"The issue of health care is second only to an economic recovery, and the issue of health care bears very heavily on an economic recovery because of the factors of cost and competitiveness," according to Senator Arlen Specter (above). Senator Specter was one of two Philadelphians to speak at this year's annual meeting. The other was Philadelphia Mayor Edward G. Rendell, who offered welcoming remarks.

Annual Meeting Wrap-Up

Held: October 23-25, 1992, at the Adam's Mark Hotel, Philadelphia

Number of delegates in attendance: 254

Number of resolutions and reports submitted: 138

County medical societies reporting 100 percent attendance: Allegheny, Beaver, Berks, Cambria, Centre, Chester, Clearfield, Clinton, Columbia, Delaware, Elk/Cameron, Franklin, Lancaster, Lehigh, Mercer, Montgomery, Northumberland, Philadelphia, Tioga, Union, Venango, Westmoreland, York

Key issues discussed: Certificate of need, concurrent care, drug-resistant tuberculosis, HIV/AIDS, living wills, medical school issues, physician referral, prioritization of health care, redistricting, tort reform, workers' compensation reform

Guest speakers:

Raymond Scalettar, MD, Chairman, AMA Board of Trustees (see "Discharge Summary," page 48)
Senator Arlen Specter (R-PA)
The Honorable Edward G. Rendell, Mayor of Philadelphia
Mrs. S. Bruce Gerber, President, AMA Auxiliary
Mrs. Victor F. Greco, President, Pennsylvania Medical Society Auxiliary

The tuberculosis threat

The incidence of drug-resistant tuberculosis in Pennsylvania has become a growing concern to health care providers within the last year, even considered by some to be a "crisis." The delegates advocated that the Society become involved by: 1) studying appropriate recognition of drug-resistant tuberculosis as a threat to public health; 2) studying appropriate actions to protect health care workers and uninfected persons from the disease; and 3) seeking increased federal funding to develop drugs to treat the disease.

HIV/AIDS issues

Delegates reaffirmed Society policies on HIV/AIDS issues by adopting with no debate three HIV-related proposals. First, the Society will approve the principles of early, unencumbered testing for HIV so patients can benefit from early, non-toxic, and cheaper anti-viral therapy. Such action will allow the Department of Health to function in the best interests of all citizens. The Society will then seek legislation to make these principles law.

Second, the Society will assess the guidelines of each Pennsylvania medical school for management of HIV-infected students with regard to medical degree requirements and to

encourage each school to adopt policy that permits an HIV-infected medical student to complete courses and clerkship requirements to receive a medical degree.

Finally, the Society will support HIV-positive physicians by: 1) helping to protect them from discrimination; 2) reinforcing the need for confidentiality in testing; 3) promoting active involvement in the legislative arena; 4) developing disability guidelines that assist the HIV-positive physician in procuring appropriate fiscal support; and 5) aiding HIV-positive physicians in placement in alternate career tracks if necessary. The resolution also directs the Society to urge the AMA to take similar action.

Other key actions

Other key resolutions adopted direct the Society to:

- Support the physician's use of any facility providing procedural, laboratory, diagnostic, and other testing services which the physician determines to be in the best interest of the patient's health and well-being; and if the physician has a financial interest in the facility, that should be disclosed and alternate facilities offered.
- Seek a clear definition of concurrent care and uniform guidelines for the use and reimbursement of such care under Medicare.
- Continue its efforts in regard to workers' compensation, tort reform, and the certificate of need (CON) process. The Society maintains opposition to a permanent tie-in to the Medicare payment system for the workers' compensation bills pending in the state legislature; it advocates meaningful tort reform in Pennsylvania; and it supports abandonment of the CON process with no phase-out period.
- Create a living will kit containing relevant information concerning withholding or withdrawal of life-sustaining medical care. The kit will be publicized and offered free-of-charge to members and at a price to non-members.

SOCIETY SECTIONS HOLD ANNUAL ASSEMBLIES

Each year during the annual meeting, the Society's sections meet separately to review and discuss resolutions for consideration by the delegates, to elect new officers, and to conduct other business. Educational segments are often part of the program as well.

This year meetings were held by the Hospital Medical Staff Section (HMSS), the Young Physician Section (YPS), the Resident Physician Section (RPS), the Medical Student Section, and the Medical School Section.



Mrs. Edward (Sue) Pan was installed as president of the Pennsylvania Medical Society Auxiliary for 1992-93 during its annual convention, October 23-25, at the Adam's Mark Hotel, Philadelphia. The convention program included the Auxiliary's annual House of Delegates meeting, committee meetings, district caucuses, and a business session, as well as several fund-raising and social events.

Election Results

The State Society House of Delegates elected the following new officers and delegates during its October 1992 meeting:

President: Donald G. Ferguson, MD, Allegheny County

President Elect: Martin A. Murcek, MD, Westmoreland County

Vice President: John H. Hobart, MD, Northampton County

Speaker of the House: Jonathan E. Rhoads Jr., MD, York County

Vice Speaker of the House: Howard A. Richter, MD, Delaware County

New Trustees:
John J. McAndrew, MD, Third District
Carol E. Rose, MD, Thirteenth District
Rebecca Kunkel, Medical Student Section

Delegates to AMA:
R. William Alexander, MD, Berks County
Richard B. Baltz, MD, Dauphin County
Doris G. Bartuska, MD, Philadelphia County
Joseph B. Blood Jr., MD, Bradford County
Betty L. Cottle, MD, Blair County
James B. Donaldson, MD, Philadelphia County
Victor F. Greco, MD, Luzerne County
Lee H. McCormick, MD, Allegheny County
John S. Parker, MD, Westmoreland County
Howard A. Richter, MD, Delaware County
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Donald H. Smith, MD, Northampton County

Alternate Delegates to the AMA:
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Isadore Brodsy, MD, Philadelphia County
George F. Buerger Jr., MD, Allegheny County
Charles J. Cattano, MD, Allegheny County
Robert G. Doe, MD, Lancaster County
Thomas F. Freenock Jr., MD, Delaware County
Mark S. Friedlander, MD, York County
Jay L. Funkhouser, MD, Beaver County
Julian Katz, MD, Philadelphia County
Robert M. Kemp, MD, Lancaster County
John D. Lane, MD, Bucks County
John A. Malcolm Jr., MD, Union County
Carl A. Sirio, MD, Dauphin County
Ferdinand L. Soisson Jr., MD, Cambria County

AMA Delegate, Resident: Michael P. Moulton, MD

AMA Delegate, Student: James M. Brian

Committee to Nominate Delegates and Alternates to the AMA:
Wilma C. Light, MD, Westmoreland County

Judicial Council:
Betty L. Cottle, MD, Blair County
Henry H. Fetterman, MD, Lehigh County



Dr. John McAndrew



Dr. Carol Rose (left) and Rebecca Kunkel

Hospital Medical Staff Section

A total of 58 members attended this year's HMSS assembly October 22. During an open forum, the medical staff debated a number of important issues, including county society mini-internship programs, global fees, Medicare reimbursement, patient questionnaires, and physician apathy within the medical staff. They considered two resolutions, one dealing with RBRVS and another focusing on peer review.

Resolution 92-64—calling for the AMA to write a report outlining the specific RBRVS payment schedule for each year, for each physician category, and for each section of the country until RBRVS is fully implemented—was adopted by the HMSS and referred by the House to the Board for further study. Resolution 92-53—regarding Keystone Peer Review Organization (KePRO) quality issues and already in the House—was supported by the HMSS and adopted by the House.

The meeting concluded with a four-hour medical staff seminar, "Taking Surprises Out of Hospital Planning for Medical Staffs," cosponsored by the HMSS and the Institute for Physician Leadership of the Society's Trust.

Newly elected officers and members of the HMSS Governing Council are: James G. Pitcavage, MD, chairman; John W. Lehman, MD, vice chairman; Wilma C. Light, MD, secretary; and William W. Lander, MD, member-at-large.

Young Physician Section

Forty young physicians attended the Sixth Assembly of the Society's YPS, also held October 22. The section discussed two resolutions which they submitted to the House.

Though the House referred for further study Resolution 92-61, calling for the Society to develop guidelines for limitations on terminal patient care, it did adopt Resolution 92-63 addressing workers' compensation reform. The adopted resolution calls for the Society to oppose a permanent tie-in to the Medicare payment system for pending legislation.

YPS participants attended two educational seminars: "How You Can Make A Difference in the Legislative Arena,"—presented by Representative Ellen Harley (R-Montgomery); Karl Meyers, MD, Montgomery County physician involved in Representative Harley's campaign; and Larry Light, Society director of governmental relations—and "Effective Communications," presented by the Leadership Institute of the Society's Trust.

Newly elected officers and members of the YPS Governing Council are: John R. Martell Jr., MD, chairman; Robert M. McNamara, MD, vice chairman; Mary M. Haus, MD, secretary; and Aaron D. Bleznak, MD, member-at-large.

Resident Physician Section

The resident physicians were particularly concerned about funding for the state's medical schools. Resolution 92-62, urging the state to restore full funding, was adopted by the House.

Twenty-seven resident physicians and guests attended "Stress, Relaxation, and the Dynamics of Change During Residency Training," in which Timothy P. Brigham, PhD, of Thomas Jefferson Medical College, discussed the pressures, tensions, and strains inherent in residency training and practice.

Newly elected officers and members of the RPS Governing Council are: Jennifer Trottman, MD, chairman; Joyann Kroser, MD, vice chairman; Elizabeth Burns, DO, secretary; and Ajay K. Goyal, MD, Caren Kieswetter, MD, and Jerome S. Schroeder, MD, members-at-large.

Medical Student Section

Approximately 35 students attended the Medical Student Section assembly on October 22. Topping the agenda was discussion of Resolution 92-65 on medical student membership dues payments. Adopted by the House, the resolution directs the Society to offer one-time, multiple-year dues for medical student members.

Judy Linger, MD, of the AMA-RPS Governing Council, led the one-and-a-half-hour educational session, "Health Care Reform: A National and State Perspective."

Newly elected officers and members of the Medical Student Section Governing Council are: Amber L. Chatwin, chairman; Randolph B. Wood, vice chairman; Peter B. Kang, secretary; Rebecca L. Kunkel, trustee representative; and Kenneth W. Anderson and Kara M. Nakisbendi, members-at-large.

Medical School Section

Seven members attended the annual meeting of the Society's Medical School Section, held October 22. Discussion centered on membership and several education and science resolutions before the House.

Also, as a result of a meeting held between representatives of the state's medical schools and Society leaders, the section drafted, approved, and submitted for House consideration resolution 92-62 concerning medical school funding.

In other business, the section re-elected Klaus M. Bron, MD, as chairman. Doris G. Bartuska, MD, was newly elected as vice chairman.

John H. Hobart, MD, Easton, was elected vice president of the State Society, succeeding Martin A. Murcek, MD, who has become president elect. Dr. Hobart will become president in 1994.



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House of Delegates Action on 1992 Resolutions

This is an overview of actions from the October 23-25 annual meeting in Philadelphia. Brief summaries of Resolutions 1-57 appeared in the October issue of *Executive Report*; summaries for Resolutions 58-66 have been incorporated into this update.

92-1: Prison health care. Adopted as amended.

92-2: Cost of medical school and educational loan interest. Substitute resolution adopted.

92-3: Arbitrary and unfair differential payment of physicians. Adopted as amended.

92-4: AIDS/HIV testing and reporting. Adopted.

92-5: Incineration of hazardous waste. Referred to the Board for further study.

92-6: Guidelines for certification of home health care. Referred for study.

92-7: Physician fee and service review. Referred to the Board for further study.

92-8: Opposition to the American Hospital Association policy for health care reform. Adopted as amended.

92-9: Identification of organizations and coalitions of which the Society is a member. Adopted.

92-10: Establishment of a registry for physicians. Not adopted.

92-11: Adequate reimbursement for medical services in accident cases involving Medical Assistance and settlement or trial awards. Adopted.

92-12: Family violence. Adopted.

92-13: Tort reform. Adopted.

92-14: Information on generic drugs. Referred to the Board for further study.

92-15: PACE requirements for prescribing. Referred to the Board for further study.

92-16: Appeals process for public health decisions. Referred to the Board for further study.

92-17: Society Auxiliary unification. Not adopted.

92-18: Society funding of Auxiliary. Not adopted.

92-19: Physician fee posting. Withdrawn.

92-20: Abortion. Not adopted.

92-21: Restructuring or redistricting of the Society. Combined (92-21 and 92-52), substitute resolution adopted.

92-22: Costs for pharmaceuticals. Adopted as amended.

92-23: Requirement for annual medical evaluations—clients of county MH/MR offices and service agencies. Referred to the Board for further study.

92-24: Study of Young Physician Section. Adopted.

92-25: Newly licensed physician status for dues payment. Adopted.

92-26: Standardized membership transfer process. Referred to the Board for further study.

92-27: Quarterly report on House actions. Adopted as amended.

92-28: Change in KePRO criteria for rejection of payment. Adopted as amended.

92-29: Managed care plans—patient's acceptance requirement. Adopted.

92-30: Continuity of care. Adopted.

92-31: Pilot program to increase membership by reducing AMA, State Society, and county medical society dues. Adopted.

92-32: Dues freeze and prioritization of Society activities. Adopted.

92-33: Installment payment of dues. Referred to the Board for further study.

92-34: Pesticide-herbicide toxicity instruction. Adopted as amended.

92-35: Misuse of hypnosis and other techniques of "memory enhancement." Adopted.

92-36: CLIA '88 Act. Adopted.

92-37: Physician referrals. Adopted.

92-38: OSHA regulations. Substitute resolution adopted.

92-39: Drug-resistant tuberculosis. Adopted as amended.

92-40: Provider-specific taxes. Adopted.

92-41: Laboratory panels. Adopted.

92-42: Student loan repayment. Adopted as amended.

92-43: Reimbursement for concurrent care. Combined (92-43 and 92-44), amended, substitute resolution adopted.

92-44: Concurrent care. Combined (92-43 and 92-44), amended, substitute resolution adopted.

92-45: Tax-exemption of health care expenses. Adopted.

92-46: Confirmed HIV positivity. Adopted.

92-47: Amphetamine usage. Adopted.

92-48: Electronic billing. Adopted.

92-49: Tobacco and smoking. Referred to the Board for further study.

92-50: Telephone services. Adopted.

92-51: Medicare statewide charge class. Not adopted.

92-52: Redistricting. Combined (92-21 and 92-52), substitute resolution adopted.

92-53: KePRO response information. Adopted as amended.

92-54: National Credential Verifying Service. Combined (92-54 and 92-56), amended, substitute resolution adopted.

92-55: Temporary license. Referred to the Board for further study.

92-56: Acceptance of NCVS for completion of licensure. Combined (92-54 and 92-56), amended, substitute resolution adopted.

92-57: Physician living will information kit. Adopted.

92-58: Child safety restraints in commercial aircrafts. Calls for the Society to support in principle laws governing mandatory infant and child safety restraints in commercial aircrafts. Not accepted as business of the House.

92-59: Referendum institution. Calls for the Society to permit referendums for the membership on legislative matters that have or may have deleterious consequences for physicians. Not accepted as business of the House.

92-60: Pennsylvania Medigap insurance. Calls for the Pennsylvania Insurance Department to permit the sale of 10 Medigap policies allowed by federal statute in the Commonwealth. Adopted.

92-61: Limitations of terminal patient care. Calls for the Society to develop guidelines for limitations on invasive or heroic treatment options for the terminally ill. Referred to the Board for action.

92-62: State funding for all Commonwealth medical schools. Calls for Society to urge the governor and the state legislature to restore full funding for all Pennsylvania medical schools. Adopted.

92-63: Workers' compensation reform. Calls for the Society to oppose a permanent tie-in to the Medicare payment system for the workers' compensation bills pending in the Pennsylvania legislature. Adopted as amended.

92-64: Projected physician reimbursement schedule for RBRVS. Directs the Society to ask the AMA to outline the RBRVS payment schedules for future years by physician category. Referred to the Board for further study.

92-65: Medical student membership fee. Calls for the Society to offer one-time, multiple-year dues for medical student members. Adopted.

92-66: Management of HIV-infected medical students. Calls for the Society to study Pennsylvania medical school guidelines on managing HIV-infected students with regard to the completion of medical degree requirements, and encourages each school to adopt a policy that permits an HIV-infected medical student to complete courses and clerkship requirements and receive a medical degree. Adopted.

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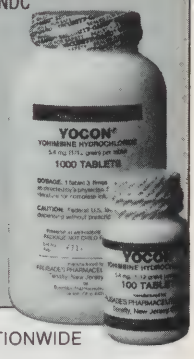
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1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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ACTIONS OF THE BOARD OF TRUSTEES, OCTOBER 22 AND 25, 1992

SOCIETY EXPANDING LIABILITY REFORM EFFORTS

Medical liability reform has been a priority for the Pennsylvania Medical Society for the past few years. Now that health care reform has also become a "hot" topic, the Society will expand its efforts to promote the inclusion of medical liability reform as a major component of health care reform legislation.

With liability reform favored by President Bush and President Elect Clinton during the presidential campaign, and with Society polling showing public support for capping awards, there is evidence that the public is more receptive now than in recent years to changing the existing system. At the same time, the Trial Bar continues to fight tenaciously against reform, and battles over liability caps are shaping up in California, Indiana, and Washington, DC.

Aware that the public will be bombarded by contrary views on the issue, the Society is preparing to respond through ongoing media contacts and increasing public relations activities, and by building community coalitions to emphasize the need for medical liability reform, a major emphasis within the Society's health care reform proposal, currently under draft.

At its October 22 meeting, the Board of Trustees approved the development of a plan of action for the effort by the Society's Division of Communications and Public Affairs. Activities could include news releases, interviews, editorial board visits, media "events," public forums, public educational displays, and lobbying efforts.

SOCIETY TO STUDY CME JOINT SPONSORSHIP

The Society, with approval of the Board, will study the possibility of offering its services as a joint sponsor for hospital and other continuing medical education (CME) programs which lack the resources to become fully accredited sponsors.

In a joint sponsorship, the Society—as an organization accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide category 1 CME credit—would be required to participate in the planning of the program to assure that the program meets the essentials for CME as defined by ACCME.

Until recently, a number of medical schools and large institutions offered non-accredited sponsors the ability to jointly sponsor programs with them in order to secure category 1 credit. Many of those larger institutions have decided to drop their joint sponsorship arrangements for several reasons. Now, some hospitals that do not wish to become accredited sponsors themselves are looking for a joint sponsor, and a number of them have contacted the Society.

The study will seek to answer questions raised by the Society's Council on Education and Science addressing hospital interest in the program, the costs and benefits of such a program, what resources would be required, etc. Results of the study and further recommendations of the council will be presented to the Board upon completion.

BOARD AFFIRMS HEALTH CARE REFORM POSITION

The Board adopted for further development the positions and concepts reflected in a draft health care reform position paper developed by the Society's Committee on Long Range Assessment.

The draft incorporates a number of recommendations concerning such issues as tort reform, relief from administrative hassles, and the need for patient cost consciousness. As part of the finalization process, the Society will distribute the draft to consumer groups, specialty societies, and other interested organizations.

A summary of the Society's reform proposals will be published in a series of articles in PENNSYLVANIA MEDICINE, beginning with the January 1993 issue.

For additional information or copies of the entire position paper, members may contact the Society's Division of Communications and Public Affairs at 1-800-228-7823. Also, for a related story, see "Of Politics, Health Care, and Change," page 8.

BOARD APPROVES 1993 PRIORITIES

The Board of Trustees approved the following Society priorities for 1993:

- Health care reform
- Liability tort reform
- Managed care
- Membership
- Public health
- Third-party reimbursement

Priorities are determined each year as guidance for the Pennsylvania Medical Society's overall activities, but by no means limit the scope of issues addressed by the Society.



Dr. Lawrence



Dr. Greco



Dr. Soisson

BOARD LEADERS ELECTED

At a reorganizational meeting following the last session of the 1992 House of Delegates on October 25, the Board of Trustees elected the following leaders: John W. Lawrence, MD, chairman; Victor F. Greco, MD, vice chairman; and Ferdinand L. Soisson Jr., MD, secretary.

Dr. Lawrence, Second District, assumes the position held by John H. Hobart, MD, Third District, for three years. Dr. Greco, Twelfth District, has been a board member for seven years; and Dr. Soisson, Eleventh District, returns as secretary for his fourth term.

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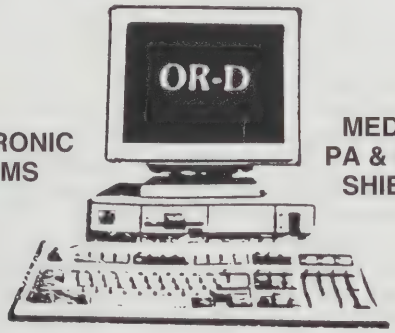
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1992 ELECTION REVIEW AND ANALYSIS

While "vote for a change" was the keystone of many campaigns this year, in the political backrooms on election night there was a collective sigh of relief: the tide of change in Pennsylvania was much more shallow than expected.

The following is a brief review and analysis of federal and state races for the House and Senate. **Bold** print indicates candidates supported by the Pennsylvania Medical Political Action Committee (PAMPAC) and the American Medical Political Action Committee (AMPAC). In Congress, 86 percent of those candidates supported by PAMPAC won, while at the state level, that number reached 95 percent; PAMPAC supported a candidate in 84 percent of the contested elections.

Federal races: Senate and House

With a foundation of more than 1.5 million ticket-splitting voters, **Arlen Specter** (R) edged Lynn Yeakel (D) to win re-election to his third term in the Senate. The race was as close as most observers predicted.

The tide of change did reach the Congressional delegation as **James Greenwood** (R) defeated incumbent **Peter Kostmayer** (D-Bucks)* and Paul McHale (D) defeated incumbent **Don Ritter** (R-Lehigh/ Northampton). In both instances, the successful challenger had service in the state legislature. Greenwood is currently a state Senator and McHale served in the House. Both won by good-sized margins.

In two key Congressional races in the western part of the state, **Rick Santorum** (R-Allegheny) overcame a large voter registration deficit to win a second term, and **Austin Murphy** (D-Washington) escaped with a narrow victory. As expected, **Ron Klink** (D-Allegheny/Westmoreland) won election in the 4th District where he had defeated Congressman Joe Kolter in the primary.

There were two "open" seats where the incumbent had retired, both in the east. Tim Holden (D-Schuylkill) defeated **John Jones** (R) to keep the former Yatron seat Democratic. In a much closer race, with a preliminary margin of only 1,000 votes, Marjorie Mezvinsky (D-Montgomery) defeated **Jon Fox** (R). That seat had been held by Republican Lawrence Coughlin.

When the Congress reconvenes, the Pennsylvania delegation in the House will have 11 Democrats and 10 Republicans. Republicans lost a net of two seats in the delegation.

Senate remains under GOP control

With only one "open" seat at stake, the State Senate will be virtually unchanged. **Hal Mowery** (R) was elected to replace retiring John Hopper (R) in the 31st District (Cumberland). The only variables are: 1) the seat which will be vacated in the 10th District (Bucks) when Senator Jim Greenwood moves to the Congress in January; and 2) the status of Senator Frank Pecora. Previously a member of the Republican caucus, Pecora campaigned as a Democrat for Congress and lost to Rick Santorum. His district was moved across the state to Chester County.

All other incumbent candidates won re-election. Physicians were most active in the 49th District (Erie) where many had made individual personal contributions to **Steve Brooder** (R), a challenger to Buzz Andrezeski (D). Unfortunately the bid fell short.

If Pecora remains a part of the Republican caucus, the GOP keeps their 26-24 margin.

State House stays Democratic

In stark contrast to the upper chamber, the House of Representatives will have as many as 37 new faces. However, even with all of those changes, the balance of power will only shift slightly.

There were five incumbents who lost their seats outright. In Philadelphia **Connie McHugh** (R) lost to William Keller (D). The other defeated incumbents were Democrats. In Lebanon County Peter Zug (R) ousted Ed Arnold (D). Curt Bowley (D) of Warren County lost to James Lynch (R), and after a recount, Ken Cole (D) of Adams County lost by 10 votes to Stephen Maitland (R).

One race literally pitted two incumbents against each other. **John Wozniak** (D) defeated Leona Telek (R) in a battle set up by re-apportionment in the 71st District (Cambria).

Republicans did comparatively well in districts which were re-located by re-apportionment. Winners were Tim Hennessey (R-Chester), **David Steil** (R-Bucks), **Katie True** (R-Lancaster), **John Fichter** (R-Montgomery), and Todd Platts (R-York). The only Democrat to win a re-located seat was former Representative Frank Yandrisevits (Lehigh/Northampton).

The Democratic majority was protected by critical victories in four of the 29 seats where a member of the House had retired. Five of the seats changed party in this election, and the Democrats won four of them. In Delaware County Thaddeus Kirkland (D) and Greg Vitali (D) won seats vacated by Robert Wright and Steve Freind. Lawrence Curry turned the seat formerly held by Charlie Nahill in Montgomery County into the Democratic column, and Dante Santoni did the same with Paul Angstadt's former seat in Berks County. Only in Cumberland County was the trend reversed: Republican Al Masland was elected to replace Democrat John Broujos.

With one seat close enough to be decided by a re-count, the House Democratic majority slipped to 106-97 and may go to 105-98. Currently there are 107 members in the majority.

Statewide races

Although the incumbents won re-election in all three statewide races, there was more excitement than many would have expected just a few weeks before the election.

Ernie Preate (R) turned back a challenger by a narrow margin to win another four-year term as attorney general, and Barbara Hafer (R) did the same in the auditor general race. In both races the lead changed several times as returns were counted election night. State Treasurer Catherine Baker Knoll was re-elected by a much larger margin and is now seen by many as a strong candidate in the 1994 Democratic Gubernatorial primary.

** In the Bucks County congressional race, PAMPAC supported Greenwood and AMPAC supported Kostmayer.*

Larry L. Light, the Society's director of legislative affairs, contributed to this page.

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A Plan for State Society Interaction with Toxic Release Program

David R. Brill, MD

At the April 22, 1992, meeting of the Society's Commission on Environmental and Occupational Health, Deborah Williams of the U. S. Environmental Protection Agency (EPA) asked for the support and involvement of the Pennsylvania Medical Society in the EPA's newest project, the Toxic Release Inventory (TRI).

TRI was mandated under Section 313 of SARA (Superfund Amendments and Reauthorization Act, 1986). At issue was the unregulated and largely unappreciated release of significant amounts of toxic chemicals by manufacturers who, in many cases, had no concept of how much and what was going into the air, water, and land. At the same time, Title III of the same act authorized the emergency planning and community right-to-know programs into which TRI is closely tied. EPA's goal is to reduce toxic emissions substantially by collecting and publishing data which will induce manufacturers to voluntarily curb any questionable practices or enable citizens to "assist" corporations in so doing.

This is not yet a national program, but it will become one in several years. EPA wanted a trial run in a heavily populated, highly industrial state with a large volume of toxic releases, an active environmental community, and close proximity to Washington, DC. Pennsylvania, which ranks fifth nationally in industrial pollution, was an obvious choice for a pilot study. The state was chosen in late 1991, and the Society was quickly targeted because of its understandable concern for public health.

The TRI consists of a mandatory reporting program for large-scale, potential toxic waste generators. To be targeted by the program, an industry must be involved in manufacturing; employ 10 or more workers; *and* manufacture, import, or process more than 25,000 pounds of toxic chemicals per year. At present, over 22,000 users nationwide are enrolled. The chemicals to be reported are confined to just over 300 substances, which tend to be among the more hazardous. The program focuses on what substances are present, how they are used, amount and where releases occur, how much is shipped and where, and how much is treated and how.

The EPA readily admits to some significant shortcomings of the TRI. For one, large amounts of toxics can be released by manufacturers who do not meet the above criteria, such as dry cleaners. Automobile emissions and toxic substances used by private citizens are completely invisible to the system. In addition, the rate and timing of releases are not recorded.

From an epidemiological standpoint, a sudden, massive release has different effects than a slow, sustained release. Not all chemicals are studied. Moreover, atmospheric conditions and ecological pathways during releases are not available through the TRI. Finally, and very importantly, data such as these inherently cannot address issues of causality.

The Society commission recommended and the Board of Trustees has adopted the following stance:

- TRI may provide useful information on toxic releases for physicians, citizens, and corporations.
- Making this information available to members is consistent with the Society's position on issues of environmental and occupational health.
- The Society is concerned about the potential for inappropriate—even malicious—use of information.
- The Society is concerned about an unintentional, yet potentially deleterious effect upon hospitals, physicians, and manufacturers of pharmaceuticals, paper and x-ray products, and durable medical devices which may translate into unnecessary expense or curtailment of services of patients.
- The Society *does not* endorse the TRI, but agrees to make the availability of the TRI known to Society members via PENNSYLVANIA MEDICINE and *Executive Report.*

More information on the TRI is available from: the Society's Department of Educational and Scientific Affairs, (800) 228-7823; most county libraries; and the National Library of Medicine's TOXNET database, (301) 496-6531, which may be accessed by hospital libraries or a variety of computer network means (floppy disks, magnetic tapes, or microfiche). Members need to be aware that while some forms of access are free, others may involve substantial fees.

Dr. Brill is chairman of the Society's Commission on Environmental and Occupational Health.

NIH PANELS ISSUE REPORTS

Two National Institutes of Health (NIH) consensus development statements are now available from the NIH Office of Medical Applications of Research. The statements contain recommendations and conclusions concerning: 1) diagnosis and treatment of depression in late life; and 2) triglyceride, high density lipoprotein, and coronary heart disease.

Each statement was prepared by a panel of experts who considered scientific evidence on the subjects at consensus development conferences at NIH. Such conferences bring together researchers, practicing physicians, representatives of public interest groups, consumers, and others to carry out scientific assessments of drugs, devices, and procedures in an effort to evaluate their safety and effectiveness.

Free, single copies of the consensus statement on depression in late life or the consensus statement on triglyceride, high density lipoprotein, and coronary heart disease are available from:

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MEDICARE CONVERSION FACTOR UPDATES SET

The 1993 Medicare physician fee schedule conversion factor update, which becomes effective January 1, 1993, is 3.1 percent for surgical services and 0.8 percent for non-surgical services.

The 3.1 percent increase reflects a 2.7 percent increase in the Medicare Economic Index (MEI) adjusted by performance under the Medicare Volume Performance Standard (MVPS) for surgical services. For Fiscal Year 1991 the MVPS for surgical services was 3.3 percent, and actual expenditures went up by 2.9 percent, or 0.4 percent less than the standard. This results in an update of 3.1 percent (2.7 percent increase in the MEI plus 0.4 percent).

For non-surgical services, the 0.8 percent reflects the MEI of 2.7 percent adjusted by the performance under the MVPS. For 1991 the MVPS for non-surgical services was 8.6 percent, and actual expenditures went up by 10.5 percent, or 1.9 percent more than the standard. The result is an upgrade of 0.8 percent (2.7 percent increase in the MEI minus 1.9 percent).

MEDICARE PAYMENT DEADLINES CHANGED

Under current Medicare rules, participating physicians who file "clean claims," as defined by the Health Care Financing Administration (HCFA), are to be paid no sooner than 14 days, but no later than 17 days from date of carrier receipt. For non-participating physicians the payment ceiling is 24 days. If payment is made on or after the payment ceilings, interest is added to the payment.

Under a new policy—which technically took effect in October, but won't be implemented until January 1, 1993—payment ceilings are no longer determined by the par/non-par status of physicians. Rather, payment ceilings for claims will be determined by the method of submission: electronic versus paper.

Physicians who file electronically will be paid no sooner than 14 days after carrier receipt of the claim, while paper claim filers will be paid no sooner than 27 days. Ironically, there is a good possibility that the government will have to pay interest on virtually every paper claim filed.

The new law did not eliminate the 24-day maximum carriers have to pay clean claims before having to pay interest. Therefore, there is at least a three-day interest payment which will be made on practically every paper claim filed. For electronic claims, if a carrier failed to meet the 14-day payment goal, Medicare would not have to pay interest on the claim until 24 days after receipt by the carrier.

MONITORING IMPORTANT TO PAYMENT REFORM

Early Claims Review and Comparative Performance Reports are two activities of importance in monitoring implementation of Medicare payment reform (see PENNSYLVANIA MEDICINE, October 1992, page 28). A third activity of importance is an educational program known as Global Surgery Monitoring.

Part of standardizing carrier payment policies was the development of global surgery package modifiers. These new modifiers include: **25**—significant, separately identifiable evaluation and management service by the same physician on the day of a procedure; and **79**—unrelated procedure by the same physician during a postoperative period. Modifier 79 may also be used to indicate that the procedure reported is a second or subsequent one, related but separate from the first in a series of staged procedures when CPT does not contain appropriate codes.

Medicare is monitoring the use of these two new modifiers. If a physician's modifier utilization places him or her in the 95th percentile (in an array of lowest to highest utilization), the physician is notified. Currently under review are second-quarter services—April 1-June 30, 1992. The utilization comparisons are neither locality or specialty specific. Therefore, all state physicians were compared against all other state physicians who met the following criteria:

- *For Modifier 79*—physicians who have been paid for a minimum of 15 surgical services with a global surgical postoperative period of 10 and 90 days, and one or more services or procedures where the 79 modifier was used.
- *For Modifier 25*—physicians who have been paid for a minimum of 15 surgical services with global surgical postoperative periods of 0, 10, and 90 days, and one or more services or procedures where the 25 modifier was used.

The number of global monitoring letters sent out for each Pennsylvania Blue Shield contract area is shown below.

A peculiar problem has been identified for the specialty of rheumatology. Rheumatologists have received a disproportionate number of reports. A large number of evaluation and management visits during which an arthrocentesis is administered, necessitating the use of these modifiers, is causing this distortion. Pennsylvania Blue Shield is discussing with HCFA the possibility of comparing rheumatologists against their peer group rather than all the physicians in the state.

Dennis L. Olmstead, the State Society's director of medical economics, contributed to this page.

Distribution of Global Monitoring Letters

State	Modifier 25	Modifier 79
Pennsylvania	153	118
District of Columbia	27	20
Delaware	5	5
New Jersey	71	62
Total	256	205

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JANUARY 1993

JANUARY 6th
Lupis Nephritis: Clinical Course and Therapy - 1993
Gerald B. Appel, M.D.
Professor of Clinical Medicine, Director, Clinical Nephrology, Columbia-Presbyterian Medical Center, New York, NY

JANUARY 13th
Experimental Mitral Regurgitation: The Hearth and Sarcomere
James F. Spann, M.D.
Professor of Medicine, Director, Division of Cardiology, Director, Gazes Cardiac Research Institute, Medical University of South Carolina, Charleston

The Adrenergic Nervous System in Heart Failure
Michael R. Bristown, M.D., Ph.D.
Professor of Medicine, Head, Division of Cardiology, University of Colorado Health Center, Denver

JANUARY 20th
Hypercoagulation
S. Benham Kahn, M.D.
Professor and Vice Chair of Neoplastic Diseases, Hahnemann University

JANUARY 27th
Metabolism of Alcohol and Associated Hepatic and Metabolic Disorders
Charles Lieber, M.D.
Professor of Medicine & Pathology, Mount Sinai School of Medicine, Director, GI-Liver Training Program and Alcohol Research & Treatment Center, Bronx, VA Medical Center, Bronx, NY

FEBRUARY 1993

FEBRUARY 3rd
Parkinsons: Pitfalls of Treatment
Norman Leopold, D.O.
Clinical Associate Professor of Neurology, Hahnemann University

David Roeltgen, M.D.
Associate Professor of Neurology, Hahnemann University

Jay S. Schneider, Ph.D.
Associate Professor of Neurology, Hahnemann University

FEBRUARY 10th
Hypercholesterolemia: A Second Opinion
Sylvan L. Weinberg, M.D.
Clinical Professor of Medicine, Wright State University School of Medicine, Chairman of Cardiology, Good Samaritan Hospital, Dayton

FEBRUARY 17th
Treatment of Human Immunodeficiency Virus Infection
Martin Hirsch, M.D.
Professor of Medicine, Harvard Medical School, Infectious Diseases Unit, Massachusetts General Hospital, Boston

FEBRUARY 24th
Legionella
Victor Yu, M.D.
Professor of Medicine, University of Pittsburgh School of Medicine
Chief, Infectious Diseases Section, VA Medical Center, Pittsburgh

MARCH 1993

MARCH 3rd
Critical Reading of the Medical Literature
Robert H. Fletcher, M.D.
Editor, Annals of Internal Medicine, Philadelphia

MARCH 10th
Vesicular Billous Disorders
Richard L. Spielvogel, M.D.
Professor and Acting Chair, Department of Medicine, Director, Division of Dermatology, Hahnemann University

MARCH 17th
Clinical Pathological Case Presentation
Brad B. Moore, M.D.
Sunil Natrajan, M.D.
Savas Petrides, M.D.
W. Clay Warnick, M.D.
Chief Medical Residents, Hahnemann University

MARCH 24th
Skeletal Changes in Spaceflight
Sara Bond Amaud, M.D.
Research Scientist, Life Science Division, University of California/San Francisco

MARCH 31st
Acute Myocardial Infarction in the '90s
J. Ward Kennedy, M.D.
Professor of Medicine, Director, Division of Cardiology, University of Washington School of Medicine, Seattle

Wednesday Medical Seminar Series

8:30 a.m. to 3:30 p.m.

JANUARY 13, 1993
Mechanisms and Treatment of Congestive Heart Failure
James F. Spann, M.D.
Michael R. Bristow, M.D., Ph.D.

FEBRUARY 17, 1993
Treatment of HIV and HIV-Related Opportunistic Infections
John G. Bartlett, M.D., Martin Hirsch, M.D.
Rob Roy MacGregor, Peter Selwyn, M.D.

MARCH 10, 1993
Dermatology
Richard Spielvogel, M.D.

Seminar Director: Allan B. Schwartz, M.D., Professor and Vice Chair of Medicine, Director, Continuing Medical Education for the Department of Medicine

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Looking for Changes in Retroactive HCFA Directives

Donald E. Harrop, MD

One of the most difficult jobs we have in the peer review business is trying to explain that we *must* take a certain action on a case that may have occurred months (even a year or years) ago, when the rules of the game may have been just recently changed. This happens regularly with HCFA regulations, directives, policies, etc.

A perfect example of dealing with retroactive Health Care Financing Administration (HCFA) directives is when changes are made to the *Medicare Coverage Issues Manual.* Often, these revisions will modify coverage for a particular procedure, prosthetic device, etc. When this happens, a case may be denied, but the first occurrence can be paid under waiver of liability since the physician did not know or had no way of knowing that coverage was not available.

When HCFA issued new generic quality screens for ambulatory surgery review, it included the requirements for histories and physicals (H&Ps), and documentation of discharge orders. Because the Keystone Peer Review Organization (KePRO) selects its sample of cases from claims *paid* by the fiscal intermediary (FI), there is an inherent delay caused by the administrative and billing processes involved.

Cases reviewed by KePRO are, at the very least, a few months after the date of service. Sometimes a very minor error on the bill submitted by the provider may cause it to fail to pass an FI edit, and the bill will go back and forth many times before finally being paid. By the time the new generic screens were sent to the hospitals and the information was distributed to physicians, the screens were applicable to thousands of cases which occurred prior to physicians' knowledge of the new ground rules.

Of course, waiver of liability does not apply to what are considered to be quality of care issues. HCFA's position in matters such as this appears to be that the requirements for the H&Ps and documentation of discharge orders represent good medical practice and, therefore, should have always been followed. Sure, it's easy for us, when confronted with questions about the retroactive application of any of these types of new directives, to just point to HCFA with the standard answer that it was their idea. But this is getting a little old, and I'm sure that this repetitious answer does little to bolster KePRO's credibility with the medical community. Besides, we don't always agree with HCFA on policy matters, but as a contractor to HCFA, we are not in a position to criticize a policy of this nature. That type of questioning must come from outside sources.

A resolution by the Pennsylvania Delegation to the AMA was submitted to and approved by the AMA House of Delegates in 1991. That resolution called for the AMA to urge HCFA to publish in the *Federal Register* any proposed changes in processes or procedures which would affect physician practice patterns and/or delivery of medical care. We fully supported that position; however, there has been no indication to date that HCFA has taken any steps to implement it.

The 1992 Pennsylvania Medical Society House of Delegates passed a similar resolution which calls for the Society to request HCFA to provide PROs with timely notification of new or changed criteria to allow for 90 days' advance notice to physicians. We hope this meets with more success.

Dr. Harrop is president of the Keystone Peer Review Organization.

QUARTERLY REPORTS FROM KEPRO OVERSEERS

The House of Delegates, through Resolution 86-44 (Amended), has mandated the Society to provide regular reports on Keystone Peer Review Organization (KePRO) findings. The following report from the Ad Hoc Committee on KePRO Oversight covers the period July 1 through September 30, 1992. It shows the number of Medicare discharges, cases reviewed by KePRO physician reviewers, pending denials issued, final denials issued, and DRG changes made by KePRO.

KePRO Data for All Pennsylvania Hospitals—07/01/92 - 09/30/92

Medicare Discharges	▾192,762	DRG Changes	1,313
Cases Reviewed	41,383	PPS Hospitals Under IR	▾▾3
Admission Denials	735	Generic Screen Failures	33,329
Administrative Denials	143	Pending Quality Problems	6,527
Total Denials	878	Confirmed Quality Problems	436

▾ *Reflects total discharges received by KePRO for the reporting quarter.*

▾▾ *Proposed number of hospitals to begin IR.*

Robert B. Edmiston, MD, senior vice president, professional affairs, Pennsylvania Blue Shield, will retire at the end of this year after 18 years with Blue Shield. In his position, Dr. Edmiston developed and administers the participating doctor network, and is accountable for medical policy development and implementation. He also oversees utilization review, quality assurance, and Blue Shield's HMOs, and serves as medical director of Keystone Health Plan, Central, and chief executive officer of the Precertification Center of Capital Blue Cross and Pennsylvania Blue Shield. Prior to joining Blue Shield, Dr. Edmiston was a family practitioner in Harrisburg for 15 years.


Dr. Edmiston

Joseph C. Goldschmidt, MD, PhD, geriatric specialist, Delaware County Memorial Hospital, Drexel Hill, has been appointed to the Upper Darby Board of Health.

William H. Straub, MD, radiologist and nuclear medicine specialist, has been named as a fellow of the American College of Radiology.

Fred Baurer, MD, Overbrook Hills, has been named director of the Outpatient Addiction Treatment Services, The Institute of Pennsylvania Hospital, Philadelphia.


Dr. Marks

The Gerald J. Marks Professorship in Colorectal Surgery has been established at Thomas Jefferson University, Philadelphia, to honor **Gerald Marks, MD,** director of the Division of Colorectal Surgery at Thomas Jefferson University Hospital and internationally renowned colorectal surgeon.

Phillip J. Marone, MD, team physician for the *Philadelphia Phillies* and director of the Division of Sports Medicine, Thomas Jefferson University Hospital, received the 1992 Humanitarian Award from Magee Rehabilitation Hospital, Philadelphia, for his "championed and/or advanced rehabilitation medicine in the Delaware Valley."

The American College of Emergency Physicians presented **Steven J. Davidson, MD, MBA, FACEP,** division head, Emergency Medical Services, The Medical College of Pennsylvania, Philadelphia, with the Emergency Medical Services Award for his significant contributions to the field.

Albert M. Maguire, MD, ophthalmologist, has joined the faculty of the Scheie Eye Institute, Philadelphia.

Stuart L. Fine, MD, chairman, Department of Ophthalmology, University of Pennsylvania, Philadelphia, received a $75,000 grant from Research to Prevent Blindness, New York, to support research into the causes, treatment, and prevention of blinding diseases.

James Thomas Diehl, MD, Wynnewood, has been appointed chief of cardiothoracic surgery, Pennsylvania Hospital, Philadelphia.

Two national medical organizations, the Institutes of Medicine and the Federation of State Medical Boards of the United States, have selected **Darwin J. Prockop, MD, PhD,** chairman of the Department of Biochemistry and Molecular Biology and director of the Jefferson Institute of Molecular Medicine, Thomas Jefferson University, Philadelphia, to serve as a distinguished representative in the field of medicine.

Laurie Varlotta, MD, pediatric physician and pulmonologist, has joined St. Christopher's Hospital for Children, Philadelphia, as director, Disorders of Breathing/ Apnea Program.


Dr. Varlotta

CORRECTION

On page 20 of the September 1992 issue of PENNSYLVANIA MEDICINE, the On-Call advertisement incorrectly identifies the medical title of Dennis W. Rhoades as *MD*. Dr. Rhoades is a licensed *DO*.



Marilyn Tucker Quayle, wife of Vice President Dan Quayle, visited the Breast Cancer Center at Albert Einstein Medical Center, Philadelphia, as the hospital marked the 20th anniversary of Einstein's pioneering role in the development of the mammogram. Pictured (left to right) are: Harold Isard, MD, director, Gershon-Cohen Breast Clinic at Einstein; Robert Somers, MD, director, Einstein Breast Cancer Center, and chairman, Department of Surgery; Marilyn Tucker Quayle; Ellie Mack, MS, RN, MEd; Collette Sweitzer, RNS; Mark Kaplan, MD; Lisa Jablon, MD; and Angelica Montesano, MD.

Trends in Staff Compensation

The Health Care Group

Despite the very precarious health care environment of the '90s, the market for medical personnel appears to be stabilizing. For the second consecutive year, physicians have increased their employees' salaries by an average of four to seven percent—approximately mirroring cost-of-living increases.

According to The Health Care Group's Staff Salary Survey—an annual survey reporting practices' employee pay figures for 23 different job slots; reporting low, average, and high salary figures on a regional and national basis; and separating the data by experience levels—many positions showed no real increase, with some jobs even showing a slight decrease. For physicians, the trend toward stabilization in pay may be a welcome one; however, sustaining even minimal salary increases still presents a challenge for most medical practices.

In today's environment of lagging revenues and declining reimbursements from Medicare and other insurance carriers, physicians are feeling the effects of the sluggish economy and experiencing a drop in profitability. According to recent statistics released by the Society of Medical-Dental Management Consultants (SMD), family medicine, pediatrics, and internal medicine practices reported less profitability this year. Some subspecialties—including cardiology, gastroenterology, and oncology—saw an increase in profitability, but less than in previous years.

As a result of their relatively stable income levels, most physicians will continue to feel pressured to reduce labor costs and look to hold the line in their overhead expenses where possible. For example, many practices are increasingly sharing the burden of health insurance costs with their employees. Practices have adjusted their health insurance packages to include higher deductibles, increased co-pays, or benefits limited to employees instead of family members.

The good news for physicians is that they can now anticipate a more stable workforce with less turnover. With no significant increases in salaries, employees will be less tempted to "job hop." Because personnel costs have traditionally been the highest expense for medical practices to manage in order to maintain profitability, most physicians have had to struggle balancing expenses while maintaining quality staff. In a more stable market, physicians can take their time to recruit quality, experienced personnel at pay levels that won't set them back financially.

"As a result of their relatively stable income levels, most physicians will continue to feel pressured to reduce labor costs and look to hold the line in their overhead expenses where possible."

Nurse practitioners, PAs in demand

While most positions—including receptionists, file clerks, billing coordinators, registered nurses, and licensed practical nurses—showed no significant change, there were exceptions. Nurse practitioners and physician assistants (PAs) with two to five years' experience enjoyed salary gains of approximately 18 percent this year. This reflects an important change in how physicians perceive the value of these professionals.

More flexibility in benefits

In contrast to the stagnating salary levels among most positions, physicians have become more flexible with their benefits packages, offering options such as part-time positions, flexible hours, and dependent/child care benefits. According to The Health Care Group study, 26 percent of all medical practice employees are now working less than 35 hours a week.

The more competitive market has also provided impetus for doctors to more effectively manage their employees and evaluate performance. According to the study, more doctors (80 percent as compared to last year's 74 percent) are conducting formal review sessions, with 63 percent of them basing salary raises on a combination of merit and cost-of-living statistics.

"Right-sizing" your practice

Another important implication of the tightening market is the need for physicians to critically evaluate job duties assigned to each employee. With the growth in practice size, and the introduction of computerization and electronic claims processing in recent years, "traditional" job definitions may no longer be accurate. Moreover, the practice's division of labor may need to be reassessed. The trend today is toward "right-sizing," aiming to optimize the number of employees to meet the practice needs.

Right-sizing is only one aspect of the overall streamlining that needs to take place to stay financially healthy in today's economy. With staff compensation trends staying slow but steady, critically evaluating overhead expenses and labor costs will need to be bolstered by internal and external marketing efforts to ensure growth in the decade ahead.

The contributing authors, Dorothy R. Sweeney and Edward L. Grab, are consultants with The Health Care Group, a medical practice management consulting firm based in Plymouth Meeting.

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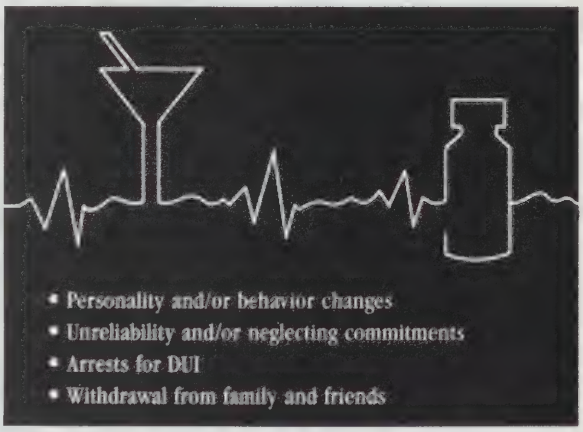
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John F. Connole, *Hollidaysburg*
Jefferson Medical College; 1938; age 80, died October 6, 1992. Dr. Connole was an ophthalmologist.•

Joseph E. Ginsberg, *New Castle*
Jefferson Medical College, 1936; age 82, died September 5, 1992. Dr. Ginsberg was an ob/gyn.•

John G. Grego, *Pittsburgh*
Hahnemann Medical School, 1938; age 79, died September 21, 1992. Dr. Grego was a general surgeon.•

Robert J. Halen, *Pittsburgh*
University of Pittsburgh Medical School, 1948; age 68, died September 24, 1992. Dr. Halen specialized in occupational medicine.•

Charles E. Kolb Sr., *Williamsport*
University of Erlangen, Germany, 1937; age 87, died September 21, 1992. Dr. Kolb was an ophthalmologist.•

Paul F. Kost, *Allison Park*
University of Pittsburgh Medical School, 1952; age 81, died September 15, 1992. Dr. Kost specialized in psychiatry.•

Ralph W. Lorry, *Philadelphia*
Jefferson Medical College, 1926; age 91; died September 20, 1992. Dr. Lorry was a general practitioner.•

Leslie S. Pierce, *Greensburg*
University of Pittsburgh, 1938; age 77, died September 15, 1992. Dr. Pierce specialized in internal medicine.•

Howard F. Reber, *Reading*
Jefferson Medical College, 1944; age 78; died September 19, 1992. Dr. Reber specialized in urology.•

Charles Weiss, *Philadelphia*
University of Pennsylvania, 1924; age 97, died September 25, 1992.•

David M. White, *Wyncote*
Hahnemann University Medical School, 1967; age 50, died September 26, 1992. Dr. White specialized in general surgery.•

Robert W. Willison, *Sewickley*
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Robert F. Babskie, *Nanticoke*
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Edward I. Bloom, *Philadelphia*
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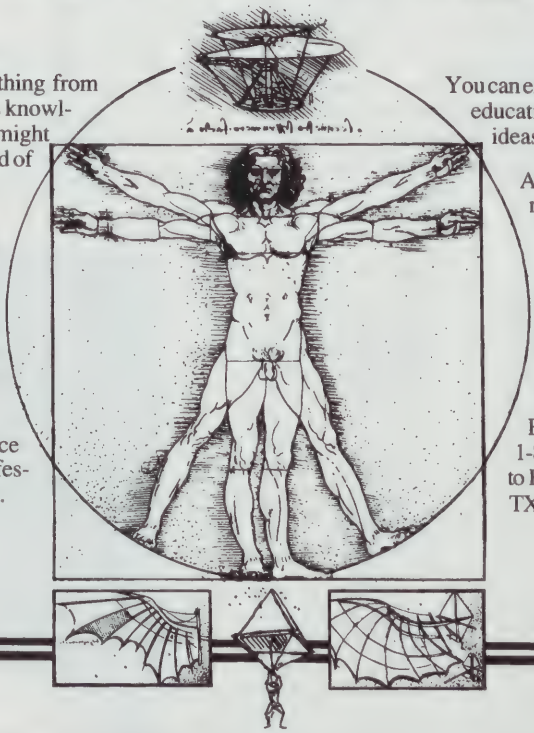
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Beware the Red Herring

Raymond Scalettar, MD

Editor's Note: The following is excerpted from a speech presented to the Society's House of Delegates at its annual business meeting just prior to the November presidential election.

It was in this state one year ago that Harris Wofford and the voters of Pennsylvania put health care reform smack in the center of the political stage, and it's stayed there ever since. It's no longer a question of *if* we're going to reform America's health care system; now it's a matter of *when* the change will occur and what form it will take. Literally every doctor—and all our patients—will be affected, because the very face of health care delivery in America is going to change. There are dozens of reform plans on the table [nationwide], but there's one aspect of the issue that hasn't been put to rest yet...the red herring.

A red herring has been smoked and cured, and it has an odor that's all its own. In Merry Old England, they'd drag a red herring across the trail to confuse the dogs during a hunt. Well, there's a red herring that's been dragged across the campaign trail right here in America that's been distracting voters from what's really going on. The red herring I'm talking about is the one that blames doctors for the high cost of health care in America today.

"There's a red herring that's been dragged across the campaign trail right here in America that's been distracting voters from what's really going on."

We hear it in the rhetoric of some politicians. We read it on the editorial pages of our newspapers. We sometimes even hear it from our own patients. What voters are not being told is that the escalating cost of meeting the country's health care needs is largely driven by illnesses and deaths among ordinary Americans themselves. Just take a look at what's happened with four health care hot spots in only the past year—smoking, violence, substance abuse, and AIDS.

- In the past twelve months, 400,000 smokers died. Caring for those smokers who did *not* die cost the health care system $52 billion.
- Violent assaults left 45,000 men, women, and children quadriplegic in the past year, requiring a lifetime of care that comes with a bill of as much as $600,000 per victim.
- About 375,000 drug-exposed babies started life with enough medical problems to cost almost $24 billion over the next five years.
- By the third quarter of this year, nearly 250,000 people had been diagnosed with AIDS—each costing about $75,000 for treatment.

Each is a serious health problem; each comes with an enormous price tag. Yet, in the face of facts as cold and hard as these, it's the doctors who are still catching the blame for the high cost of health care in America today. This is a dangerous allegation to let stand unanswered, [and] unless doctors respond, the allegation takes on a life of its own and becomes perceived as fact and not as the fiction that it really is. Once planted, the allegation grows in the fertile soil of public skepticism.

It's no secret this year that the American people are disappointed and angry with the leaders, institutions, and professions that serve them. They are frustrated that political leadership at all levels has failed to adequately address the social problems that affect life in every U.S. community.

This voter anger was part of Pennsylvania's election last year, and the same anger helped propel health care to the forefront nationally. The public knows that America's health care infrastructure is in trouble, but what the public may not yet fully realize is how big a physical price we've all paid as a result.

This, then, is what we have to tell them: that doctors are at the very front line of the health care system.

It could be said of the health care crisis that seldom has so much been written and talked about that affects so many and is understood by so few. What *is* understood by many, however, is that doctors are visible and tangible symbols of a threatening and complex issue. But, since antiquity, doctors have also been powerful symbols of help and healing. It's no accident that the majority of Americans continue to rank their *own* doctor as among the most honest and trustworthy of all the professionals.

That is our strength, and it is from that position that we can continue to remind our patients and our fellow citizens of the real truth of the matter: that the medical profession is not so much part of the problem, but instead, we're at the heart of the solution.

Dr. Scalettar is board chair of the American Medical Association.

Pennsylvania Medical Society

Auxiliary

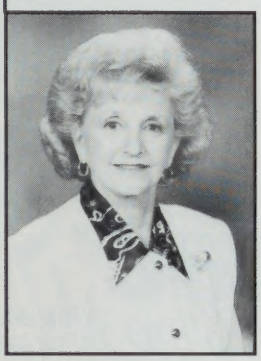
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The object of the Pennsylvania Medical Society Auxiliary is exclusively educational and charitable and to assist in programs of the Pennsylvania Medical Society that improve the health and quality of life for all people. Each community has different needs, and educational materials are provided for volunteers committed to health education and health care legislation. Programs and project ideas are available through the Project Bank catalog.

Physicians' spouses are encouraged to become members of the Medical Auxiliary in these changing times in health care and become knowledgeable so they can communicate with and help educate the community and patients when approached on health-related issues as well as legislation changing the way physicians practice medicine.

"Alone we can make a difference, but together, we can make a change."



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CONDENSED
BRIEF SUMMARY

The following is a brief summary only. Before prescribing, see complete prescribing information in Zantac® product labeling.

INDICATIONS AND USAGE: Zantac® is indicated in:
1. Short-term treatment of **active duodenal ulcer.** Most patients heal within 4 weeks. Studies available to date have not assessed the safety of ranitidine in uncomplicated duodenal ulcer for periods of more than 8 weeks.
2. **Maintenance therapy** for duodenal ulcer patients at reduced dosage after healing of acute ulcers.
3. The treatment of **pathological hypersecretory conditions** (e.g., Zollinger-Ellison syndrome and systemic mastocytosis).
4. Short-term treatment of **active, benign gastric ulcer.** Most patients heal within 6 weeks and the usefulness of further treatment has not been demonstrated. Studies available to date have not assessed the safety of ranitidine in uncomplicated, benign gastric ulcer for periods of more than 6 weeks.
5. Treatment of **gastroesophageal reflux disease (GERD).** Symptomatic relief commonly occurs within 1 or 2 weeks after starting therapy with Zantac 150 mg b.i.d.
6. Treatment of **endoscopically diagnosed erosive esophagitis.** Healing of endoscopically diagnosed erosive esophagitis occurs at 4 weeks (47%), 8 weeks (71%), and 12 weeks (84%) of therapy with Zantac 150 mg q.i.d. Symptomatic relief of heartburn commonly occurs within 24 hours of therapy initiation with Zantac.

Concomitant antacids should be given as needed for pain relief to patients with active duodenal ulcer; active, benign gastric ulcer; hypersecretory states; GERD; and erosive esophagitis.

CONTRAINDICATIONS: Zantac® is contraindicated for patients known to have hypersensitivity to the drug.

PRECAUTIONS: General: 1. Symptomatic response to Zantac® therapy does not preclude the presence of gastric malignancy. 2. Since Zantac is excreted primarily by the kidney, dosage should be adjusted in patients with impaired renal function (see DOSAGE AND ADMINISTRATION). Caution should be observed in patients with hepatic dysfunction since Zantac is metabolized in the liver.

Laboratory Tests: False-positive tests for urine protein with Multistix® may occur during Zantac therapy, and therefore testing with sulfosalicylic acid is recommended.

Drug Interactions: Although recommended doses of Zantac do not inhibit the action of cytochrome P-450 enzymes in the liver, there have been isolated reports of drug interactions that suggest that Zantac may affect the bioavailability of certain drugs by some mechanism as yet unidentified (e.g., a pH-dependent effect on absorption or a change in volume of distribution).

Increased or decreased prothrombin times have been reported during concurrent use of ranitidine and warfarin. However, in human pharmacokinetic studies with dosages of ranitidine up to 400 mg per day, no interaction occurred; ranitidine had no effect on warfarin clearance or prothrombin time. The possibility of an interaction with warfarin at dosages of ranitidine higher than 400 mg per day has not been investigated.

Pregnancy: ***Teratogenic Effects: Pregnancy Category B:*** Reproduction studies have been performed in rats and rabbits at doses up to 160 times the human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Zantac. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: Zantac is secreted in human milk. Caution should be exercised when Zantac is administered to a nursing mother.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS: Headache, sometimes severe, seems to be related to Zantac® administration. Constipation, diarrhea, nausea/vomiting, abdominal discomfort/pain, and, rarely, pancreatitis have been reported. There have been rare reports of malaise, dizziness, somnolence, insomnia, vertigo, tachycardia, bradycardia, atrioventricular block, premature ventricular beats, and arthralgias. Rare cases of reversible mental confusion, agitation, depression, and hallucinations have been reported, predominantly in severely ill elderly patients. Rare cases of reversible blurred vision suggestive of a change in accommodation have been reported. Rare reports of reversible involuntary motor disturbances have been received.

In normal volunteers, SGPT values were increased to at least twice the pretreatment levels in 6 of 12 subjects receiving 100 mg q.i.d. intravenously for 7 days, and in 4 of 24 subjects receiving 50 mg q.i.d. intravenously for 5 days. There have been occasional reports of hepatitis, hepatocellular or hepatocanalicular or mixed, with or without jaundice. In such circumstances, ranitidine should be immediately discontinued. These events are usually reversible, but in exceedingly rare circumstances death has occurred.

Blood count changes (leukopenia, granulocytopenia, and thrombocytopenia) have occurred in a few patients. These were usually reversible. Rare cases of agranulocytosis, pancytopenia, sometimes with marrow hypoplasia, and aplastic anemia and exceedingly rare cases of acquired immune hemolytic anemia have been reported.

Although controlled studies have shown no antiandrogenic activity, occasional cases of gynecomastia, impotence, and loss of libido have been reported in male patients receiving Zantac, but the incidence did not differ from that in the general population.

Incidents of rash, including rare cases suggestive of mild erythema multiforme, and, rarely, alopecia, have been reported, as well as rare cases of hypersensitivity reactions (e.g., bronchospasm, fever, rash, eosinophilia), anaphylaxis, angioneurotic edema, and small increases in serum creatinine.

OVERDOSAGE: There has been limited experience with overdosage. Reported acute ingestions of up to 18 g orally have been associated with transient adverse effects similar to those encountered in normal clinical experience (see ADVERSE REACTIONS). In addition, abnormalities of gait and hypotension have been reported.

When overdosage occurs, the usual measures to remove unabsorbed material from the gastrointestinal tract, clinical monitoring, and supportive therapy should be employed.

Studies in dogs receiving dosages of Zantac® in excess of 225 mg/kg per day have shown muscular tremors, vomiting, and rapid respiration. Single oral doses of 1,000 mg/kg in mice and rats were not lethal. Intravenous LD_{50} values in mice and rats were 77 and 83 mg/kg, respectively.

DOSAGE AND ADMINISTRATION: (See complete prescribing information in Zantac® product labeling.)

Dosage Adjustment for Patients With Impaired Renal Function: On the basis of experience with a group of subjects with severely impaired renal function treated with Zantac, the recommended dosage in patients with a creatinine clearance less than 50 mL per minute is 150 mg or 10 mL (2 teaspoonfuls equivalent to 150 mg of ranitidine) every 24 hours. Should the patient's condition require, the frequency of dosing may be increased to every 12 hours or even further with caution. Hemodialysis reduces the level of circulating ranitidine. Ideally, the dosing schedule should be adjusted so that the timing of a scheduled dose coincides with the end of hemodialysis.

May 1992

Glaxo Pharmaceuticals
DIVISION OF GLAXO INC.

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Zantac® Syrup:
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ZA2617 Printed in USA October 1992

